Authorization to Release Medical Information

Date of Request: _____

To: _____
Name of individual or entities in possession of Health Information

Address: _____

Office Tele#: _____ Office Fax #: _____

I, _____ DOB: _____
Name of recipient or legally authorized representative

Hereby Consent and Authorize You To Release to Dr.,

Circle one: All Records X-Rays/Labs Progress Notes

Pertaining The Health Care Services That Were Provided To:

_____
Name of Recipient (Please print)

During the following dates of Treatment: _____

This authorization is given for the sole purpose of: _____

I understand that this authorization is subject to revocation at any time, except to the intent that the individual or entity that is to make the disclosure has already taken action in reliance upon it.

I also understand and agree that this authorization will terminate only upon the execution of my written statement indicating my intent to revoke this authorization and that without such written revocation this authorization shall remain in full force and effect and shall not otherwise expire.

Date: _____ Signature: _____

It is the policy of this medical practice that we will adopt, maintain, and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California Law