

Authorization to Receive or Release Medical Information

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act 1981, Section 56 et seq. of the California Civil Code.

PATIENT NAME (Please Print)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
PATIENT ADDRESS	CITY, STATE, ZIP CODE	
GIVE OTHER NAME PATIENT RECEIVED TREATMENT UNDER		

I HEREBY AUTHORIZE (those named below):		TO FURNISH TO (those named below):	
NAME OF HOSPITAL OR PROVIDER OF HEALTH CARE		NAME	
ADDRESS		ADDRESS	
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE	
PHONE #	FAX #	PHONE #	FAX #

THE FOLLOWING INFORMATION FROM MY RECORDS IN YOUR FILE:

<input type="checkbox"/> HISTORY AND PHYSICAL EXAMINATION	<input type="checkbox"/> CONSULTATIONS
<input type="checkbox"/> OPERATIVE AND PATHOLOGY REPORTS	<input type="checkbox"/> PROGRESS NOTES
<input type="checkbox"/> LABORATORY AND X-RAY REPORTS	<input type="checkbox"/> IMMUNIZATIONS
<input type="checkbox"/> ER/URGENT CARE	<input type="checkbox"/> DISCHARGE SUMMARIES
<input type="checkbox"/> OTHER _____	<input type="checkbox"/> SEND ME ENTIRE FILE

DATES OF ABOVE:

THE USE OF MY RECORDS IS TO BE LIMITED TO THE FOLLOWING (Check One):

<input type="checkbox"/> HEALTHCARE	<input type="checkbox"/> AUTO ACCIDENT
<input type="checkbox"/> WORKERS COMPENSATION (Accident Date)	<input type="checkbox"/> OTHER _____

DURATION: This authorization shall become effective immediately and shall remain in effect:

UNTIL DATE SPECIFIED: ____/____/____

AS LONG AS NECESSARY FOR THE REQUESTER TO FULFILL THE OBLIGATIONS REQUIRED BY THE ACTIVITIES UNDERTAKEN.

AUTHORIZATION: I, the undersigned, being (check one):

THE ABOVE-NAMED PATIENT

THE LEGAL REPRESENTATIVE OF THE ABOVE-NAMED MINOR OR INCOMPETENT PATIENT

THE SPOUSE OR PERSON FINANCIALLY RESPONSIBLE FOR THE ABOVE-NAMED PATIENT
(Only where the information authorized for release is sought for the sole purpose of processing an application for health insurance or enrollment in a non-profit hospital plan, health care service plan or employee benefit plan and the patient is to be an enrolled spouse or dependent thereunder.)

THE BENEFICIARY OR PERSON REPRESENTATIVE OF THE ABOVE-NAMED PATIENT WHO IS DECEASED

Do hereby and request that the above-named provider of health care release to the person or entity named above, subject to the limitation and uses stated herein, the medical information requested above.

I further understand that I have the right to receive a copy of this authorization upon my request. COPY REQUESTED & RECEIVED

DATE	SIGNATURE OF PATIENT/SPOUSE/PARENT/CONSERVATOR/ GUARDIAN/PATIENT'S REPRESENTATIVE	RELATIONSHIP TO PATIENT
PRINT NAME	ADDRESS (if other than that of Patient)	CITY, STATE, ZIP CODE

DATE	WITNESS
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I hereby further authorize the release of the following confidential information which is protected under the California Welfare and Institutions Code, Section 5328. This authorization shall be valid until the date stated above.

PSYCHIATRIC RECORDS SUBSTANCE ABUSE HIV/AIDS

DATE	SIGNATURE OF PATIENT/SPOUSE/PARENT/CONSERVATOR/ GUARDIAN/PATIENT'S REPRESENTATIVE	RELATIONSHIP TO PATIENT
DATE	WITNESS	