

Completion of this document authorizes the use and/or disclosure of individually identifiable health information, as set forth below, consistent with California and Federal laws concerning the privacy of such information.

Failure to provide ALL information requested may invalidate this authorization.

Your Rights

- I may refuse to sign this authorization, which invalidates this authorization
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the physician office entity to which I originally submitted the authorization.
- My revocation will be effective upon receipt, but will not be effective to information disclosed prior to the date of revocation.
- I have a right to receive a copy of this authorization.
- Treatment, payment, enrollment or eligibility for benefits is not dependent on whether I sign this authorization, except:
 - For research related treatment.
 - When the authorization is for eligibility/enrollment/underwriting/risk rating determination.
 - When the sole purpose for creating the requested protected health information is to disclose to a third party.

Personal Information (please print clearly)

Patient Name:		Social Security Number:	-	-
Date of Birth:	/	/	Telephone:	()

Information to be released

I hereby authorize:

Name:		Organization:	
Address:			
City:		State:	
		Zip Code:	

to release the following medical information contained in the patient's medical record.

Information to be released to:

Name:			
Address:			
City:		State:	
		Zip Code:	

Type of information to be released (Limited to two (2) years of information unless otherwise stated) Check all boxes acceptable to release.

1. General Release

<input type="checkbox"/> ALL RECORDS	From:		To:	
<input type="checkbox"/> Medical Records excluding protected records	From:		To:	
<input type="checkbox"/> Test Results (specify)	From:		To:	
<input type="checkbox"/> Records pertaining to specific medical data; (i.e. Motor Vehicle accident, immunizations).	From:		To:	
	Specify:			

2. Information Protected by State/Federal Law

<input type="checkbox"/> Sexually Transmitted Disease Diagnosis/Treatment or counseling (includes HIV/AIDS)	From:		To:	
<input type="checkbox"/> Drug Abuse/Alcoholism Diagnosis/Treatment	From:		To:	
<input type="checkbox"/> Mental Health Diagnosis/Treatment	From:		To:	

3. Insurance Company Requesting a Copy of Your Medical Record
 Please be advised that this office has been contracted by your Life/Health/Disability insurance company to release your medical record in its entirety. By complying with this request you are forfeiting the confidentiality of your Protected Health Information (PHI). You are allowing the release of personal notes, examination findings, diagnosis, test results and treatment plans. Please understand that by releasing this information you may suffer the loss of coverage entirely. These ramifications are based on subjective interpretation of findings in your medical record and compared to your insurance company's actuarial data. As a result, the insurance company's interpretation of your overall health may not always coincide with your physician's overall opinion of your medical health.

4. This authorization expires: / /
 Date

If blank, authorization will expire 1 year from date of signature.

 PATIENT SIGNATURE (or Legal Representative) _____
 Date

Limiting your authorized release may lead to minor delay in mailing records. Some records may include both protected and unprotected information, therefore; exclusions may create an incomplete document. This authorization applies ONLY to this request. Future requests will require another signed form. All requests will require 14 days for completion.