JOHN MUIR HEALTH

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

PLEASE PRINT

PATIENT NAME: _____ **SOCIAL SECURITY #:** _____

DATE OF BIRTH: ___/___/_____ **TELEPHONE #: ( )** _____

INFORMATION TO BE RELEASED

I hereby authorize Dr. / NP _____

_____

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 RELEASE (Limited to two (2) years of information unless otherwise stated).

CHECK ALL BOXES ACCEPTABLE TO RELEASE

1. GENERAL RELEASE

- ☐ ALL RECORDS From: _____ To: _____
- ☐ Medical Records excluding protected records From: _____ To: _____
- ☐ Test Results (specify) From: _____ To: _____
- ☐ Records pertaining to specific medical data; From: _____ To: _____

  (i.e. Motor Vehicle accident, immunizations). Specify _____

2. INFORMATION PROTECTED BY STATE/FEDERAL LAW

- ☐ Sexually Transmitted Disease Diagnosis/Treatment or counseling (includes HIV/AIDS) From: _____ To: _____
- ☐ Drug Abuse/Alcoholism Diagnosis/Treatment From: _____ To: _____
- ☐ 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 bases on subjective interpretation of finding 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 my overall opinion of your medical health.

_____ ___/___/_____

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.