AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME ____ DOB: ________________________
ADDRESS: ____
SSN # ______-_______-_______ PHONE # ( ) ____________________

I AUTHORIZE YOU TO OBTAIN HEALTHCARE INFORMATION FROM:

____
PHYSICIAN /HOSPITAL NAME

____
ADDRESS

____
CITY/STATE/ZIP

________________ ________________
PHONE # FAX #

I AUTHORIZE YOU TO SEND/DISCLOSE HEALTH CARE INFORMATION TO: [ ] PICK UP

____
PHYSICIAN /HOSPITAL NAME

____
ADDRESS

____
CITY/STATE/ZIP

________________ ________________
PHONE # FAX #

SPECIFY RECORDS CHECK THE BOX IN WHICH TYPE OF INFORMATION IS TO BE DISCLOSED (PLEASE CHECK AND SIGN)

[ ] ALL MEDICAL INFORMATION
[ ] PSYCHIATRIC INFORMATION __________ (INITIALS)
[ ] DRUG/ ALCOHOL ________ (INITIALS)
[ ] HIV TEST RESULTS_______ (INITIALS)
[ ] LAST OFFICE VISIT
[ ] LAST COLONOSCOPY
[ ] MEDICATION LIST
[ ] BONE DENSITY
[ ] LAST REPORTED RADIOLOGY RESULTS
[ ] LAST PAP/ MAMMO
[ ] LAST REPORTED EKG
[ ] IMMUNIZATION RECORD
[ ] LAST REPORTED LAB RESULTS
[ ] OTHER PLEASE SPECIFY: ____

REASON FOR DISCLOSURE
[ ] CHANGE OF PHYSICIAN [ ] FURTHER MEDICAL CARE [ ] REFERRAL OR SECOND OPINION [ ] PERSONAL
[ ] INSURANCE APPLICATION/ BENEFITS

[ ] OTHER PLEASE SPECIFY: ____

* THERE MAY BE FEES FOR PROVIDING COPIES *

DURATION: This authorization shall become effective immediately and shall remain in effect until __________ (enter date) or for one year from the date of signature if no date entered.
REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.
REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.
A copy of this authorization is valid as original.

____ ________________________
Signature of Patient or Patient's representative Date

____
Indicate Relationship (If signed by other than the Patient)

* * * IF 20 PAGES OR MORE, PLEASE MAIL RECORDS TO: * * *

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1901 OUTLET CENTER DRIVE #200
OXNARD, CA 93036
PHONE: (805) 981-8300 FAX: (805)981-8302

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