

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME _____

DOB: _____

ADDRESS: _____

SSN # _____ - _____ - _____

PHONE # () _____

I AUTHORIZE YOU TO OBTAIN HEALTHCARE INFORMATION FROM:

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

PHYSICIAN /HOSPITAL NAME

PHYSICIAN /HOSPITAL NAME

ADDRESS

ADDRESS

CITY/STATE/ZIP

CITY/STATE/ZIP

PHONE #

FAX #

PHONE #

FAX #

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

- | | | |
|---|--|--|
| <input type="checkbox"/> ALL MEDICAL INFORMATION | <input type="checkbox"/> LAST OFFICE VISIT | <input type="checkbox"/> LAST PAP/ MAMMO |
| <input type="checkbox"/> PSYCHIATRIC INFORMATION _____ (INITIALS) | <input type="checkbox"/> LAST COLONOSCOPY | <input type="checkbox"/> LAST REPORTED EKG |
| <input type="checkbox"/> DRUG/ ALCOHOL _____ (INITIALS) | <input type="checkbox"/> MEDICATION LIST | <input type="checkbox"/> IMMUNIZATION RECORD |
| <input type="checkbox"/> HIV TEST RESULTS _____ (INITIALS) | <input type="checkbox"/> BONE DENSITY | <input type="checkbox"/> LAST REPORTED LAB RESULTS |
| <input type="checkbox"/> LAST REPORTED RADIOLOGY 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.

REVOCAION: 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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OXNARD, CA 93036
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