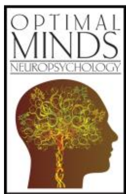

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GENERAL MEDICAL RECORDS RELEASE
Authorization for Use or Disclose of Protected Health Information

Please complete the following information:
Patient Name: ______________________________ Medical Record Number: _____________________
Date of Birth: ______________________________ SSN: _____________-________-_______________
Address: __________________________________ Phone: (________) __________-_______________
City, State, Zip: ____

I authorize the custodian of records of (healthcare provider/organization)___________________________
____
to disclose/release the protected health information described below* (check all applicable):

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/Radiology records
- ☐ Billing Records
- ☐ Abstract/Summary
- ☐ Pharmacy/Prescription Records
- ☐ Other (Describe Specifically)

***Note**: If there records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following date(s): _________________________________
Please send the records listed above to (use additional sheets if necessary:

Name: ___________________________________ Name: ___________________________________
Address: _________________________________ Address: _________________________________
____ ____
Phone: __________________________________ Phone: __________________________________
Fax: ____________________________________ Fax: ____________________________________

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box).
- ☐ For my health care
- ☐ For payment/insurance
- ☐ For employment purposes
- ☐ Other (please specify): ____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

____ ____
Signature of Patient (or patient's personal representative) Date

____ ____
Printed name of patient representative Representative's authority to sign (i.e., parent, guardian, executor)

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Santa Rosa, CA 95404
(707) 522-0202

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Suite 3
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(925) 389-6723