AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize _____
Name of physician or health care provider

_____
Address

_____
Address

_____
Phone number

_____
Fax number

To release □ my or □ my child's personal health and medical information as described below to the following person(s) or health care provider(s)

_____
Name of person or health care provider

_____
Address

_____
Address

_____
Phone number

_____
Fax number

The information to be disclosed is/are:

□ Complete medical record
□ Discharge Summary
□ Progress Notes
□ Consultation reports
□ Immunizations
□ Radiology Reports
□ Laboratory report(s)
□ Other: _____

Specify date(s) for release of protected health information _____

The purpose of the disclosure is for □ Health Care Services, □ Other: _____

Authorization is effective as of the date of signing _____, and expires 6 months thereafter _____ (date). I understand that the protected health information disclosed may not be further used by the recipient unless another authorization is obtained from me or unless such use is specifically permitted by law: California health and safety code section 123100-12349; civil code section 56.10-56.16. Copies may be subject to a fee.

Patient/Parent or legal guardian' signature printed name Date

Witness signature printed name Date