

**4. Duration**

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here. \_\_\_\_\_

**5. Patients Right to Revoke**

This authorization is subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, with the exception that the disclosing party or others have acted in reliance upon this authorization.

**6. Redisclosure**

I understand that the recipient may not lawfully further use or disclose the PHI unless another authorization is obtained from me or unless such use or disclosure is required or permitted by law.

The recipient may use the health information authorized on this form for the following purposes:

- Patient is transferring care
- Information needed for follow up care by primary care physician
- Information needed to work in conjunction with specialist
- Other: \_\_\_\_\_

Please note that all requests require 14 days for completion.

\_\_\_\_\_  
Patient Signature (or Legal Representative) \_\_\_\_\_  
Date

If signed by someone other than patient, indicate relationship: \_\_\_\_\_

<b>Office Use Only</b>	
Date sent out: _____	By: _____

# Authorization To Release Patient Health Information

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Telephone #: ( \_\_\_\_ ) \_\_\_\_\_

## Information to be Released

I hereby authorize Dr. \_\_\_\_\_ to release the following medical information contained in my patient medical record.

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ Fax Number: \_\_\_\_\_

State/Zip: \_\_\_\_\_

Information to be Released to: Dr. \_\_\_\_\_

**Address:** 140 Gregory Lane, Suite #280  
**City:** Pleasant Hill  
**State/Zip:** California 94523

**Phone Number:** (925) 288-0828  
**Fax Number:** (925) 288-0829

## Type of Information to be Released:

*(Limited to 2 years of information unless otherwise stated)*

### 1. General Release

- All Records
- Medical Records excluding protected records
- Test Results (specify)
- Records Pertaining to specific medical data (specify)

From: \_\_\_\_\_ To: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_

### 2. Information Protected by State / Federal Law

- Sexually Transmitted Disease (includes HIV/AIDS)
- Drug Abuse / Alcoholism Diagnosis / Treatment
- Mental Health Diagnosis / Treatment

From: \_\_\_\_\_ To: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_

### 3. Insurance Company Requesting a Copy of Your Medical Record

Please be advised that this office has been contacted 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 information you may suffer the loss of coverage entirely. These ramifications are based on subjective interpretation of findings in your medical records 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 our overall opinion of your medical health.

