



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name OR PLACE STICKER HERE	Date of Birth	Phone: E-mail:
Patient Address, City, State & Zip		

Release Records FROM:**Doctor / Facility:** _____**Address:** _____**Phone/Fax:** _____**Release Records TO: (multiagency page 2, if applicable)****Doctor / Facility:** _____**Address:** _____**Phone/Fax:** _____**OPTION OF DELIVERY (PLEASE CIRCLE): PATIENT PORTAL / FAX / PHONE / MAIL / PICK-UP / OTHER****RECORDS TO BE RELEASED (please circle: DENTAL OR MEDICAL):**

<input type="checkbox"/> Patient Entire Record	<input type="checkbox"/> Visit Notes	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Radiology (incl images)	<input type="checkbox"/> Other
Dates: FROM: _____			TO: _____	

PLEASE CHECK BELOW TO INCLUDE:

<input type="checkbox"/> Behavioral Health Records	<input type="checkbox"/> Sexually Transmitted Diseases	<input type="checkbox"/> HIV	<input type="checkbox"/> Alcohol & Substance Abuse
<input type="checkbox"/> Verbal <input type="checkbox"/> Written	Initial _____	Initial _____	Initial _____
Initial _____ Date: _____	Date: _____	Date: _____	Date: _____

PURPOSE OF DISCLOSURE: Change of Provider / Dentist Continuity of Care Other: _____

I authorize my information to be released for the purpose of my care. **This authorization shall remain in effect for one year from date of signature unless a different date is specified here (date):** _____. I understand I can revoke this authorization in writing any time, except when the information has already been released. I understand that my health information may not be used or shared in other ways unless I give another authorization, or unless that use is specifically allowed by law. California recipients are required to obtain your authorization before further disclosing this information. The facility, its employees, officers, and doctors are released from any legal liability for disclosing my health information to the extent they are authorized. I understand that a copy of this authorization is as valid as the original. I have a right to a copy of this authorization.

_____	_____
SIGNATURE of Patient/Parent / Guardian or Authorized Representative	Date
_____ () _____	_____
PRINT NAME AND PHONE of Parent / Guardian or Authorized Representative	Relationship to Patient