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):

☐ Patient Entire Record	☐ Visit Notes	☐ Laboratory Results	☐ Radiology (incl images - dental)	☐ Other
Dates: FROM: _____			**TO: _____**	

PLEASE CHECK BELOW TO INCLUDE:

☐ Behavioral Health Records	☐ HIV Test Result
☐ Verbal ☐ Written Initial _____ Date:_____	Initial _____ Date:_____

PURPOSE OF DISCLOSURE: ☐ Change of Provider / Dentist ☐ Continuity of Care

X Other:_____clearance to attend school_____

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 end 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**