AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Confidentiality of Medical Information Act of 1980 Sec 56 et seq. of the California Civil Code

PRINT PATIENT LAST NAME	FIRST	BIRTHDATE

ADDRESS	CITY	STATE	ZIP CODE

GIVE OTHER NAME PATIENT RECEIVED TREATMENT UNDER	PHONE NO.	MESSAGE PHONE NO.:
	( )	( )

SOCIAL SECURITY NUMBER:	CHB	MEDICAL RECORD NO.:

I HEREBY AUTHORIZE (THOSE NAMED BELOW)
NAME OF PHYSICIAN/HEALTH CARE PROVIDER/OTHER
ADDRESS
CITY/STATE/ZIP CODE
PHONE NUMBER

TO FURNISH TO (THOSE NAMED BELOW)
NAME OF PHYSICIAN/HEALTH CARE PROVIDER/OTHER
ADDRESS
CITY/STATE/ZIP CODE
PHONE NUMBER

THE INFORMATION TO BE RELEASED IS LIMITED TO THE FOLLOWING:

☐ YES	☐ NO	Progress Notes	☐ YES	☐ NO	Psychiatric Records*
☐ YES	☐ NO	Laboratory and X-ray Reports	☐ YES	☐ NO	HIV*
☐ YES	☐ NO	Pathology Report	☐ YES	☐ NO	Alcohol & Drug Abuse Record*
☐ YES	☐ NO	Immunization Booklet	☐ YES	☐ NO	Other: _____
☐ YES	☐ NO	Send entire file	For Radiology films, please contact X-ray department		

SPECIFY DATE(S) FOR ABOVE INFORMATYION TO BE SENT:

*(Under some circumstances, information in a record that mentions HIV, drug use, alcohol use or mental conditions, will require an additional authorization).

Please complete enclosed authorization if applicable.

THIS AUTHORIZATION SHALL REMAIN VALID FOR 1 YEAR OR:

The undersigned is entitled to a copy of this form upon request

Copy Requested and Received ☐ YES ☐ NO

DATE

PATIENT SIGNATURE

WITNESS

PARENT, LEGAL GUARDIAN OR REPRESENTATIVE
(ATTACH AAPPROPRIATE DOCUMENTATION)