Huntington Family Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ *Date Of Birth:*_____

Phone Number : _____

Address: _____ *City, State, Zip:* _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone Number:** _____

Facility Address: _____ **Facility Fax:**_____

City, Street, Zip Code: _____ **Physician:**_____

Dates and Type of Information to Disclose

2 years prior from last date seen ☐ **Immunization Records**

Dates Other: _____ ☐ **Lab Records** ☐ **X- Rays**

Specific Information Requested:_____ ☐ **All Medical Records**

Restrictions: Only Medical Records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to : **Huntington Family Medicine**
50 Bellefontaine St, Suite #403
Pasadena, Ca 91105
Fax: 626-792-1960 Phone: 626-792-1912

☐ **Dr. Mattai** ☐ **Dr. Sheldon** ☐ **Dr. Godwin** ☐ **Dr. Parra** ☐ **Ann Asher NP**

I understand I may revoke this Authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company that the law provides my insurer the right to contest a claim under my policy.
Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
If I fail to specify an expiration date, event, or condition, this authorization will expire one year from date signed.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that the disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____
Signature of Patient **Date**

_____ _____
Printed Name of Authorized Representative **Relationship/Capacity to Patient**

Please be sure to fax records with a cover sheet