

AUTHORIZATON FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient's Name _____ Medical Record Number _____

Address _____

Social Security Number _____ Date of Birth _____

Telephone Number _____ Work _____

I AUTHORIZE INFORMATION TO BE RELEASED FROM:

**VAILS FAMILY PRACTICE
7811 LAGUNA BLVD., SUITE 170
ELK GROVE, CA 95758
P/916.691.4300 F/916.691.4302**

TO THE FOLLOWING:

Name/Agency _____

Address _____

Telephone Number _____

PURPOSE OF RELEASE:

- Copy for personal use
- Transfer of care
- Continuing care
- Insurance company request

INFORMATION TO BE RELEASED:

- Dates: From _____ To _____.
- All Records
- Summary Medical/Surgical Packet (Most pertinent documentation as defined by your physician.)
- Standard Medical/Surgical Record Packet including laboratory and x-ray reports limited to _____ years.
- Hospital Records _____
- Lab Results _____
- X-ray Reports _____
- STD/HIV Test Results*
- Mental Health Diagnosis/Treatment*
- Drug/Alcohol Abuse Diagnosis/Treatment*
- Other _____

This authorization is valid for one (1) year from the date of consent. I understand I am entitled to a copy of this authorization upon request. I may revoke this authorization at any time in writing.

Signature of Patient/Guardian/Representative (Relationship) _____ Date

*This information is protected by State/Federal law and further disclosure will not be made without your specific written consent. A minor patient's signature is required in order to release information concerning care for: (1) pregnancy termination and sexually transmitted diseases; (2) alcoholism or drug abuse; and (3) mental health conditions. Age 14 and above for Drug and Alcohol, and Sexually Transmitted Disease Information (including AIDS/HIV); 13 and above for Mental Health Information.