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:

Name/Agency ____

Address ____

Telephone Number ____

TO THE FOLLOWING:

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

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.