Irvine Family Practice Medical Group

Authorization for Release and /or Disclosure of Medical Information

Treatment will not be conditioned on my providing or refusing to provide this authorization

Please **REQUEST** Medical Information **FROM**:	Please **SEND** Medical Information **TO**:
Name of Health Care Provider	Name of Health Care Provider
Street Address	Street Address
City, State, and Zip Code	City, State, and Zip Code

I hereby authorize_____to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.
Release and/or Disclose records and information regarding:

Name of Patient (list other names used) **Date of Birth**

Address **City** **State** **Zip** **Telephone**

DURATION: This authorization shall become effective immediately and shall remain in effect until_____or for one year from the date of signature if no date is entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED: Check the box and initial which type of information is to be released and/or disclosed:

☐ **General Medical Information: From_____to_____**

☐ **Information concerning specific injury or Treatment: From_____to_____**

☐ **X-Ray** (check one or both) ☐ **Films** ☐ **Reports**

☐ **Mental Health:**
From_____to_____ _____
Signature of Patient or Patient's Representative Date

☐ **Alcohol/Drug:**
From_____to_____ _____
Signature of Patient or Patient's Representative Date

☐ **HIV Test Results:**
From_____to_____ _____
Signature of Patient or Patient's Representative Date

☐ **Other (specifiy):**_____

I request that the Health Information released and/or disclosed pursuant to this authorization be used for the following purposes only:_____

_____

Patient or patient's Representative Signature:_____

A copy of this authorization is valid as an original.
I have the right to receive a copy of this authorization. The copy is for me to keep.