Health Information Management
823 Gateway Center Way
San Diego, CA 92102
Phone: (619) 515-2368 Fax: 619-269-0132

FAMILY HEALTH CENTERS OF SAN DIEGO

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ AKA: _____
Address: _____
City/State/Zip:
Phone: _____
Date of Birth: _____ MR #: _____

Please Indicate How to Release
☐ Electronic ☐ Paper Copy
☐ Encrypted CD

☐ **SEND TO** ☐ **OBTAIN FROM** | ☐ **VERBAL COMMUNICATION**

Name of Authorized Person or Facility: _____
Address of Person or Facility: _____
Phone#: _____ Fax#: _____

I Authorize Release of the Following Records (*check all that apply)*:

☐ Medical Information ☐ HIV & Related Information ☐ Mental Health
(includes Drug/Alcohol/HIV Related)

For Dates of Service:
From: _____ To: _____

_____
Signature *Date*

Purpose of the Request or Disclosure:
☐ Patient Care ☐ Self ☐ Legal ☐ Provider Form ☐ Other _____
(please specify)

Description of the Information to be Disclosed
☐ Immunizations ☐ Progress Notes ☐ Lab/Results Reports/Consults ☐ Newborn
☐ Procedures/EKG/Images ☐ Discharge Summaries/ER Notes ☐ Other:_____

Date Records Needed by: _____ Date of Next Appointment:_____
Unless otherwise revoked, this authorization will expire 6 months from the date signed.

I have the right to revoke this authorization by sending a signed notice stopping this authorization to the health information management department at my primary care medical home. The authorization willstop further release of information on the date my valid revocation request is received at the health information management department. I am signing this authorization voluntarily; I understand my treatment will not be affected if I do not sign this authorization. Under California Law, the recipient of protected health information under the authorization is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I have the right to receive a copy of this authorization.

PLEASE INCLUDE THIS FORM AS COVER SHEET WHEN SENDING RECORDS

Signature_____
(Patient/legal representative) Date Time

If signed by other than patient, indicate relationship:_____

Staff Name & Title:_____ Staff Extension:_____ Site:_____

PHOTOCOPY VALID AS ORIGINAL