AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Please complete in full)

Patient Name _____ **Daytime Phone No.** _____ **Date of Birth**_____

Address_____ **City, State, Zip**_____

AUTHORIZES DISCLOSURE TO:

_____
Name of Health Provider/Organization/Individual

_____
Street Address City, State, ZIP

_____
Phone No. Fax No.

TO RELEASE MEDICAL INFORMATION FROM:

_____
Name of Health Provider/Organization/Individual

_____
Street Address City, State, ZIP

_____
Phone No. Fax No.

INFORMATION TO BE DISCLOSED *(Note: Please see Disclosures Requiring Special Consent for AIDS/HIV, Mental Health, Alcohol/Drug Use)*

☐ Complete Medical Record **[OR the individual records marked below:]** Date Range: _____ to _____

☐ Office Visits Notes ☐ Laboratory Reports ☐ Hospital/Outside Agency Records ☐ Ultrasound Reports

☐ Radiology Reports ☐ EKGs and ECHO Reports ☐ Other: _____

YOUR RIGHTS REGARDING THIS AUTHORIZATION

- **Right to receive a copy of this authorization**: I understand that if I agree to sign this authorization, I may request a signed copy of the form.
- **Right to withdraw this authorization**: I understand that written notification is necessary to cancel this authorization. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. I am aware that I have the right to revoke this authorization by providing written notice to the health care provider who has been given this authorization.
- **Further Disclosure:** I hereby release **San José Clinic** from all legal responsibility or liability that may arise from the release of such information. I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I acknowledge that this information may include diagnostic studies, clinical abstracts, histories, x-rays, charts and other information, documents and opinions relevant to past, present, or future physical condition, treatment, hospitalization or care. **EXPIRATION DATE**: This authorization is effective for **90** days from the date signed unless otherwise indicated. A reproduced copy of this authorization shall be valid as the original

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of health information relating to testing, diagnosis and treatment for:

☐ AIDS/HIV/STDs ☐ Mental Health Care ☐ Alcohol/Drug Use

_____ _____
Patient or Legal Representative Signature/Relationship Date of Signature

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_____ _____
Staff Signature Date of Signature