AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name____________________________________ Date of Birth_______________

Social Security Number: ____________________________

Information requested from:

Information to be released to:

This authorization applies to the following information:

- ❑ Complete medical records
- ❑ Other____

The recipient may use my health information for the following purposes:

- ❑ Continuing health care
- ❑ Other____

Expiration:

- ❑ 6 months from date of signing.
- ❑ Other: ______________

Restrictions

California Law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California

<u>Your Rights</u>

- ❑ I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment.
- ❑ I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to my address.
- ❑ My revocation will be effective upon receipt, but will have no impact on uses of disclosures made while my authorization was valid.
- ❑ I have a right to receive a copy of this authorization.
- ❑ I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.

I hereby authorize and request that the above information be released to Romeo Medical Clinic.

Patient/Personal Representative Signature _____________________________________
Date ____________________
Relationship to Patient ____
Witness ____