



Grace Family Health, Inc.
Authorization to Release Medical Records

\*\*Form must be completed or it will delay your medical records request\*\*

Medical Record Fee: \$50

Date of Medical Records Request: \_\_\_\_\_

Patient 's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Phone: \_\_\_\_\_ D.O.B \_\_\_\_\_

I authorize Grace Family Health, Inc. to release my medical records to:

Facility Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

For the purpose of review/examination, I further authorize you to provide such copies as may be requested, the foregoing is subject to such limitations as indicated below:

\_\_\_ Entire Record (Specific dates of service, if applicable): \_\_\_\_\_
\_\_\_ Specific Information: Medication History X-rays MRI CT Scan
\_\_\_ Other Specific Information: \_\_\_\_\_

I give special permission to release any/all information regarding (Initial on Applicable Line(s) below):
\_\_\_ Substance Abuse \_\_\_ Psychiatric/Mental Health Information \_\_\_ HIV Information

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations

\_\_\_\_\_  
Patient Signature: Legal Guardian/Representative Signature Description of Authority to Act for Patient

AUTHORIZATION TO USE OR RELEASE PROTECTED HEALTH INFORMATION REGARDING MEDICAL, PSYCHIATRIC AND SUBSTANCE ABUSE RECORDS FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by the Federal confidentiality rules(42CPR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CPR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

24910 Las Brisas Road, Suite 105, Murrieta, CA 92562 Phone: (951 )231-1385 Fax: (951) 461-9191