



Holvik Family Health Center
 221 E. Caldwell Ave.
 Visalia, CA 93277
 Ph. 559-732-4726 Fax 559-732-4747

Release Medical Records

I request and give permission for the transfer of my medical records **Date:**

Name : _____ **DOB:** _____
Address: _____ **Phone:** _____

From: Holvik Family Health Center
 221 E. Caldwell Ave Visalia CA 93277
 Ph. 559-732-4726 Fax 559-732-4747

To: _____
 Doctor or Facility Name

 Address

 Phone

 Fax

All Records

-OR-

Specific Records: _____

I authorize the release of my complete health record (including records relating to mental healthcare, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).

-OR-

I authorize the release of my complete health record with the exception of the following information:

Mental Health Records

Alcohol/ Drug Abuse Treatment

Communicable Diseases

Other: _____

Signature: _____

Date: _____

This authorization is effective for up to one year after date signed by patient. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation.h