Authorization for Release of Medical Information and Protected Health Information

Timothy A. Leach, MD
Obstetrics, Gynecology and Menopause

110 Tampico Suite 210, Walnut Creek, CA
Tel: 925-935-6952 Fax: 925-935-1396

I, hereby authorize Timothy A. Leach MD Inc. to disclose my medical information to
Facility Name/Self _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Name of Patient _____ DOB _____
Signature of Patient _____ Year you were last seen _____
Phone number you can be reached at _____

Specify the records: Check the box and initial to specify which type of information is to be disclosed.
_____All previous medical information

- ○ Medical Information _____ Start Date_____ to End Date_____
- ○ X-Ray Results _____ Start Date_____ to End Date_____
- ○ Lab Results _____ Start Date_____ to End Date_____
- ○ Progress Notes _____ Start Date_____ to End Date_____
- ○ Consultation Reports _____ Start Date_____ to End Date_____
- ○ Other _____ Start Date_____ to End Date_____

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here_____.
Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.
Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorized Representative of Patient: _____ Witness: _____
Signed _____ Signed _____

Name _____ Name _____
Relationship to Patient _____ Patients _____

Please check appropriate boxes below:

- ❑ Copies of Records 1-4 pages free of charge (includes last pap, mammogram, last note or annual exam. **If no boxes are checked the free pages will be sent.**
- ❑ $30 minimum fee for copies and /or transfer of all records. Payment must be received with this request or authorization to charge card prior to records being sent.
- ❑ 10 day notice required or additional fee ($10.00) applies for a RUSH request.

I authorize Dr. Leach to charge my credit card for $ _____

- ❑ **AMEX/Visa/Master Card Discover Number _____**
  Expiration date _____ Security code on back of card _____
- ❑ **Signature _____**

Please forward these records via:

- ❑ **Mail to the address shown above POSTAGE ADDITIONAL CHARGE FOR LARGE PARCELS**
- ❑ Postage increments _____ $5.00 _____ $10.00 _____ $15.00
- ❑ **Fax to _____**

Should you have any questions, please contact us at 925-935-6952.