Authorization for Release of Medical Information and Protected Health Information

I, hereby authorize
Facility Name _____
Address_____
City_____ State_____ Zip_____
Phone _____ Fax _____

Name of Patient_____ DOB_____
Signature of Patient _____ Year you were last seen _____
Number Patient can be reached at_____

To disclose my medical information to

Timothy A. Leach, MD
Obstetrics, Gynecology and Menopause

Timothy A. Leach M.D.
110 Tampico Suite 210, Walnut Creek, CA 94598
Tel: 925-935-6952 Fax: 925-935-1396

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_____

Specify the records to be disclosed:

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:
Signed_____
Name_____
Relationship to Patient_____

Witness:
Signed_____
Name _____
Patients _____

Please forward these records via fax:

- ❑ **Fax 925-935-1396**
- ❑ **Fax 925-935-6952**

THANK YOU FOR YOUR PROMPT ASSISTANCE.
Should you have any questions, please contact us at 925-935-6952