TEMECULA VALLEY
PRIMARY CARE PHYSICIANS

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Last Name_____ Patient First Name_____ MI _____

Patient Date of Birth _____/_____/_____

My records are to be released from:

Previous Facility's / Doctor's Name_____

Telephone # (____) _____ Fax # (____) _____

Address _____ City_____ State_____ Zip_____

My records are to be released to:

Facility's / Doctor's Name_____

Telephone # (____) _____ Fax # (____) _____

Address _____ City_____ State_____ Zip_____

The records to be release are (please specify dates and type of records):

From_____ To_____

- ○ All Medical Records
- ○ All Medical Records; Last 2 years only
- ○ History and Physical Exams
- ○ Lab Reports
- ○ X-Ray Reports
- ○ Consult Reports
- ○ Other: _____

My records are to be released for the following purpose:

- ○ Changing Physicians
- ○ Continuing Care
- ○ Insurance
- ○ Other:

_____

Genetic testing, HIV, behavioral health or drug and alcohol abuse/treatment information within the requested dates will be included unless specified below:

DO NOT RELEASE (CHECK ALL THAT APPLY): __Genetic Testing __HIV __Behavioral Health __Drug/Alcohol

I may revoke this authorization at any time unless the recipient has already processed this request.
To revoke this Request: send a written notice to the place where this authorization was signed.
I May not be required to sign this authorization as a condition to receiving treatment, payments or benefits.
The recipient of the records is prohibited from re-disclosing the information without receiving a new request for disclosure or if required or permitted by law. A photocopy of this form will be considered as valid as the original.
This authorization will expire 90 days from signing.
I HAVE READ AND UNDERSTAND THE ABOVE.

Patient Name_____ Date _____/_____/_____

Patient Signature _____ Date _____/_____/_____

Parent/Legal Guardian Name_____ Date _____/_____/_____

Parent/Legal Guardian Signature_____ Date _____/_____/_____