Pediatric Center of Carmichael

6633 Coyle Ave Ste. 2 Carmichael, CA. 95608

Phone: 916-965-6560 Fax: 916-965-5672

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize:

____
Name of Disclosing Party

____
Address

____
City State Zip

To Disclose to:

____
Name of Recipient

____
Address

____
City State Zip

Records pertaining to:

____
Name of Patient

____
Address

____
Date of birth

____
Phone Number

Purpose of Disclosing medical records: _______________________________

☐ **Provide only pertinent medical records** **OR** ☐ **All of my medical records from (enter dates)**

_______________________________ _______________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, or acquired immunodeficiency syndrome (AIDS). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

EXPIRATION: This authorization will become effective immediately and will remain in effect for one year from the date of signature unless a different date is specified here ____________(date).

California Restrictions: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

YOUR RIGHTS

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment, or health plan enrollment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the Health Information Services Department at this facility.
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.

REDICLOSURE: 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.

I have a right to receive a copy of this authorization

If this box ( ) is checked, a copy was requested and received. Initial _________

Personal Representative Name: _______________________________

Personal Representative Signature: _______________________ Date: ____________

Relationship to Patient: _______________________________

Cost: There is a charge of $30 for each chart copied. Payment is expected at the time of request. For your convenience, we accept cash, visa and mastercard as a form of payment.

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED, EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.