Patient Name: ______________________________ **Medical Record#**________________
Address: ____________________________________ **Date of Birth:**__________________
City/State/Zip______________________________________ **Phone:**__________________

Please **OBTAIN** Information **FROM:**

____
Name & Title of Provider/Organization

____
Street Address

____
City/State/Zip

____
Telephone Number

____
Fax Number

Please **SEND** my medical information **TO**:

____
Name & Title of Provider/Organization

____
Street Address

____
City/State/Zip

____
Telephone Number

____
Fax Number

For the Purpose of: □ Patient Request □ Other ________________________________

List specific dates of records to be released: ______________________________________

Duration: This authorization shall begin immediately and remain in effect for one (1) year unless otherwise specified as follows: _________________________________(date or event).

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:

____

____

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected. *(Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or to the discretionary provisions of California Civil Code #56.10(x), may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.)*

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment (see page 2 of this form for certain exceptions). I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing (see page 2 of this form). My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization. I have the right to obtain a copy of this authorization.

Signature:____
(Patient/Parent/Conservator/Guardian) Date Time

If signed by other than patient, indicate relationship: ______________________________

Authorization to Release Medical Information

**********************For Office Use Only**********************

Date Received: ______________________**Date Records Sent:** ________________________

☐ **Identity of individual and/or legal representative verified**

Notes:____
____

___________________________   _____________

Medical Record Number   **Clerk Initials**

**********************Revocation of Authorization**********************

In accord with provisions of the Notice of Privacy Practices, I hereby revoke the

- **[ ] Above Authorization**
- **[ ] Authorization releasing information to** ___________________________________
- **[ ] Authorization dated** ______________________

Signature:____
(Patient/Parent/Conservator/Guardian)   Date   Time

If signed by other than patient, indicate relationship: __________________________________

**********************For Office Use Only**********************

Date Revocation Received: __________________________________

☐ Identity of individual and/or legal representative verified

____________________________   _____________

Medical Record Number   **Clerk Initials**

Exceptions: The exceptions noted in the Rights section on page 1 of this form include: authorization for research; authorization for health plan enrollment; and authorization solely for the purpose of creating protected health information for a third party.

Feather River Hospital