**ALTA CALIFORNIA MEDICAL GROUP, INC.**
**2925 N. Sycamore Drive, Suite 204/205**
**Simi Valley, CA 93065**
**Phone: 805 578 9620 Fax: 805 955 0498**

# Authorization for Release of Medical Information

TYPE OF ACCESS REQUESTED: (If selecting more than one (1) option, additional charges may apply)

☐ Paper copy of records ☐ Inspection of records (by appointment only)

☐ Transfer request ☐ Radiology CD

I request as the ☐ Patient ☐ Parent/Guardian ☐ Medical Power of Attorney (Proof of Legal documentation is required)

_____ _____

Name of Patient (Please print clearly) Date of Birth

| Please **SEND** medical information TO: | Please **REQUEST** medical information **FROM**: |
|---|---|
| _____ Name of Person or Entity to Receive Information | _____ Name of Medical Office / Provider |
| _____ Street Address | _____ Street Address |
| _____ City, State and Zip Code | _____ City, State and Zip Code |
| _____ Telephone Number | _____ Telephone Number |

**Duration:** This authorization will expire 12 months from the date signed.

**Revocation Process:** I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Alta California Medical Group, Inc.

**Right to Copy:** I have the right to receive a copy of the Authorization after I signed it.

**Re-Disclosure Statement:** I understand that once Alta California Medical Group discloses my health information to the recipient, Alta California Medical Group cannot guarantee that the recipient will not re-disclose my heath information to a third party. Third party may not be require to abide by this Authorization or applicable law governing the use and disclosure of my health.

**Specify records to be released.**
Check below with an **X** and initial all that applies with your request.

_____ ☐ All General Information (From _____ To _____ ) . General medical records may include information of diagnosis and /or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This may also include information and treatment of mental illness and use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

_____ ☐ Labs reports only _____ ☐ X-Ray reports only _____ ☐ Other (Please specify below)

_____ ☐ Immunizations only _____ ☐ Copies of X-Rays on CD _____

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Alta California Medical Group to use or disclose my health information in the manner described above,

| _____ | _____ | |
|---|---|---|
| Date | Signature of Patient or Representative | Indicate relationship (if not patient) |