MISSION RANCH PRIMARY CARE

Bryan G. Furst, M.D. • Herbert H. Lim, M.D.
J. Ross Nayduch, M.D. • Marcia F. Nelson, M.D.
A. M. Corky Rey, M.D. • Jennifer L. Parrish, M.D., Inc.
S. Daniel Wagner, D.O. • James A. Westcott, M.D.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

*****This form must be <u>completely</u> filled out in order to process your request*****

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

_____

I authorize:

_____
(person/facility to send information)

_____
(full address)

_____ _____
(phone) (fax)

To release information to:

_____
(person/facility to receive information)

_____
(full address)

_____ _____
(phone) (fax)

Please specify the type(s) of health information you authorize to be released:

□ All health information □ Lab Results □ Radiology Reports
□ Immunization Records □ Other (specify): _____

Date(s) of treatment or time period: _____

Please initial, if applicable (These records *<u>will not</u>*** be released without initials):**

_____ I specifically authorize the release of any sexually transmitted disease test results, diagnosis, and/or treatment, including HIV/AIDS.

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis and/or treatment.

_____ I specifically authorize the release of all mental health information.

114 Mission Ranch Blvd., Ste. 10 • Chico, CA 95926 • Phone: (530) 894-0500 • Fax: (530) 345-2532

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION (cont.)

The purpose for this release is:
□ At the request of the patient or representative

□ Other (please specify) _____

Personal Copies:
I understand I may be charged a reasonable fee for copies. _____ **(initial)**

NOTICE:
Mission Ranch Primary Care and other organizations/individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. Your health information may not be protected by state or federal confidentiality laws if you have authorized disclosure of your health information to someone not legally bound by these laws.

YOUR RIGHTS:
This authorization to release information is voluntary. I can refuse to sign this authorization. I need not sign the form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality laws. _____ **(initial)**

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must present a written revocation to Mission Ranch Primary Care's Medical Records Department. My revocation will be effective upon receipt, but will not be effective to the extent the disclosing party or others have acted in reliance upon this authorization. _____ **(initial)**

EXPIRATION OF AUTHORIZATION:
Unless otherwise revoked, this authorization expires on _____ (insert date or event). If no date is indicated, the authorization will expire 12 months after the date it was signed.

_____ _____
Signature (Patient, Parent/Guardian) **Patient Name (please print)**

_____ _____
Date **Relationship to patient**

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