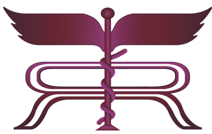

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please REQUEST medical information from:

____

Name of Health Care Provider / Medical Office / Hospital:

____

Street Address **City** **State** **Zip Code**

Please SEND Medical Information to:

☐ **Montebello Clinica Medica Familiar**
901 W. Whittier Boulevard
Montebello, CA 90640-4737
(323) 728-8588 Fax (323) 728-4444

☐ **Ontario Clinica Medica Familiar**
403 West F Street
Ontario, CA 91762-3207
(909) 988-3288 Fax (909) 988-6767

☐ **Rialto Clinica Medica Familiar**
436 S. Riverside Avenue
Rialto, CA 92376-6523
(909) 877-8868 Fax (909) 877-0008

I hereby authorize **Name of Health Care Provider / Medical Office / Hospital** noted above to release and/or disclose the medical information as indicated below to the **Clinic** I have indicated above.

Release and/or disclose records and information regarding:

____

Name of Patient (List All Names Used) **Medical Record Number** **Date of Birth**

____

Street Address **City** **State** **Zip Code** **Telephone**

DURATION:	This authorization shall become effective immediately and shall remain in effect __________ (enter date) or for one year from the date of signature if no date is entered.
REVOCATION:	This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation received.
REDISCLOSURE:	I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.
SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED:	**Check the box and initial which type of information is to be released and/or disclosed**: ☐ General Medical Information (from____________ to____________) ☐ Hospital Discharge Summary(ies)and Operative Reports (from____________ to____________) ☐ Information Regarding Specific Injury or Treatment (from ____________to____________) ☐ X-Ray / Ultrasound / Mammogram / CT Scan / MRI / EKG / Echo (circle one) ☐Films ☐Reports ☐ Laboratory Results ______________________________ Other (specify :) ______________________________

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only:

☐ Continuity of Care ☐Other ______________________________

A copy of this authorization is valid as an original.
I have the right to receive a copy of this authorization. The copy is for me to keep.

______________________ ______________________ __________

Signature of Patient or Patient's Representative | Indicate Relationship (if signed by other than patient) | Date