WESTSIDE MEDICAL CLINIC

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

I authorize the transfer of my healthcare information

TO: ☐ **TO:** ☐

FROM: ☐ **FROM:** ☐

Dr. _____ Dr. _____

Hospital: _____ Hospital:_____

Address: _____ Address:_____

_____ _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Health Information Requested:
Limit Records to: _____

- ☐ Complete Medical Records
- ☐ Last Consultation Reports
- ☐ Discharge Summary
- ☐ IMMUNIZATION RECORD
- ☐ Hospital Records
- ☐ Imaging Reports
- ☐ Laboratory Reports
- ☐ Other (specify) _____

Reason for Disclosure: ☐ Continuing patient care ☐ Other: _____

I understand that the specific information to be released may include but not limited to management of drug or alcohol abuse, mental/psychiatric illness or communicable disease. I understand this consent may be revoked at anytime in writing.

- I may revoke this authorization at any time by submitting a revocation in writing to WESTSIDE MEDICAL CLINIC.
- If may revoke this authorization, the revocation will not apply to information that has already been release in good faith before the revocation was received.
- Information disclosed pursuant to this authorization may be re-disclosed by the recipient by the recipient and no longer by the federal privacy laws.

THIS CONSENT WILL EXPIRE 180 DAYS AFTER DATE OF SIGNATURE.

→_____

Last Name **First Name** **Middle Initial** **Date of Birth**

_____

Previous Names

→_____

Signature Date

_____

Signature of Patient Representative Relationship to patient Date