ADVANCED GERIATRIC CARE
& FAMILY PRACTICE ASSOCIATES

MEDICAL RECORD RELEASE FORM

PATIENT NAME: _____ DOB: _____

PATIENT SIGNATURE: _____ DATE: _____

I AUTHORIZE RELEASE OF RECORDS FROM:

_____
DOCTORS NAME / GROUP/ FACILITY

_____
PHONE NUMBER

_____
FAX NUMBER

RELEASE RECORDS TO:

ADVANCED GERIATRIC CARE & FAMILY PRACTICE CARE ASSOCIATES
23521 PASEO DE VALENCIA STE 311
LAGUNA HILLS, CA 92653
PHONE: 949-305-2660
FAX: 949-305-2036

LAB _____

RADIOLOGY_____

CONSULT REPORT _____

ALL RECORDS _____

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. BY INITIALING I authorize the release of the following protected or sensitive information. DRUG ABUSE DIAGNOSIS/TREATMENT SEXUALLY TRANSMITTED DISEASES ALCOHOLISM DIAGNOSIS/TREATMENT AIDS/HIV TEST RESULTS INCLUDING RELATED HIGH RISK BEHAVIOR MENTAL HEALTH/TREATMENT GENETIC TESTING

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information. You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing. You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.