AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____/_____/_____

Street Address: _____

City _____ State _____ Zip _____

Previous Name (if applicable): _____

I Authorize:

Health Care Provider:_____

Street Address: _____

City _____ State _____ Zip _____

To Release the Following Medical Information from _____ through _____ :

___ Medical History, Examination, Reports ___ Hospital Records including Reports ___ X-Ray Reports

___ Surgical Reports ___ Consultations ___ Treatment or Tests ___ Laboratory Reports

___ Release ALL records ___ Other (specify) _____

Release Medical Information to:

Access OmniCare
39180 Farwell Drive, Suite 231
Fremont, CA 94538
(510) 585-2545 phone
(510) 505-9287 fax

I understand that I am not required to sign this authorization in order to receive health care benefits (treatment, payment or enrollment). However, I must sign an authorization to take part in a research study OR To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Access OmniCare based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: Fill out a revocation form (available at the Front Desk) OR Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it.
Privacy laws may no longer protect it.

Signature of Patient: _____**Date**_____