AUTHORIZATION TO RELEASE MEDICAL INFORMATION

MD Health Clinics

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

EXPLANATION:
This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the confidentially of medical information act of 1981, section56 et seq., California civil code

Patient Name: _____ DOB: _____ SSN: _____

INFORMATION TO BE RELEASED FROM:

Name/facility: _____
Address: _____
Phone: _____ Fax: _____

Information to be released to:

MD Health Clinics, Inc.
ph = 877-788-6342
fax = 949-274-8925

Information to be released:

_____

_____

I am aware of and or have been advised of the provisions of existing state and federal statutes, rules, and regulations which provide for my right to confidentiality of the information in these records.

I realize that this is a required consent and that I must voluntary and knowingly sign this authorization before any records can be released, also that I may refuse to sign, but in that event the records cannot be released.

Date: _____ Signature: _____

Signature of parent/guardian: _____

Relation to patient: _____

TO BE COMPLETED BY PATIENT

MD Health Clinics, Inc.
14591 Newport Blvd. ♦ Tustin, CA ♦ 92780
877.788.6342 phone ♦ 949.274-8925 fax