REQUEST FOR TRANSFER OF HEALTH INFORMATION

This Authorization for use or disclosure of my health information is required by the State and Federal law. Your completion of this form means that you are giving permission for the transfer of health information described below. Please review and complete this form carefully. It may be invalid if not fully completed.

PRINT Patient's name **Date of Birth**

Patient's address **Phone number**

Name of physician, office or hospital that currently has medical records

Address of facility **phone number**

I authorize my health information be released to:

James C. MacLaren M.D.
Rafael R. Soria M.D.
James L. Reape P.A.-C
Pamela Fisher F.N.P
James C. Knapp M.D.
Alisha Pratt D.O.
Marie Silva P.A.-C

FAMILY MEDICAL GROUP 911 EAST TUOLUMNE ROAD TURLOCK CA 95382
Phone 209-668-4101 fax 209-667-5479

Information to be released: [ ]Complete medical record [ ]Lab [ ]X-ray
Other (specify)_____

Special Consent is required to release the following:
Mental Health~ signature: _____
Drug/Alcohol~ signature: _____
HIV test results~ signature: _____

This authorization shall become effective immediately and shall remain in effect six months from date of Signing or other (specify) _____

PATIENT SIGNATURE **DATE**

If signed by someone other than patient, state name and relationship

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this Authorization.
- I may revoke this Authorization at any time. My revocation must be in writing, signed by me or my representative, and delivered to Family Medical Group.
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this Authorization.
- Neither treatment, payment, enrollment or eligibility for benefits will be a condition of my providing or refusing to provide this Authorization.
- Information disclosed pursuant to this Authorization could be re-disclosed by the recipient and might no longer be protected by Federal confidentiality law. However, California law prohibits the person receiving my health information from making further disclosure of it unless another Authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy the health information that I am being asked to use or disclose, if this Authorization is initiated by Family Medical Group