Family Medical Group

AUTHORIZATION FOR USE AND /OR DISCLOSURE OF HEALTH INFORMATION

This Authorization for use or disclosure of my health information is required by State and Federal law. Failure to provide all information may invalidate this Authorization. A copy of this signed Authorization will be considered as valid as the original.

PATIENT INFORMATION: (Please Print)

Name: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

I authorize my health information to be release **FROM**:

Clinic or Doctor: _____

Address: _____

Phone #: _____ Fax #: _____

I authorize my health information to be released **TO**:

Clinic or Doctor: Family Medical Group

Address: 911 E. Tuolumne Road Turlock, CA 95382

Phone #: (209)668-4101 Fax #: (209)668-3758

PURPOSE OF DISCLOSURE: ☐ Continue health care ☐ Other _____

INFORMATION TO BE RELEASED: specify dates _____

☐ Complete Medical Record ☐ Lab ☐ Xray ☐ Other (specify) _____

_____

Special Consent is required to release the following: Patient Initial Date

☐ Mental Health _____

☐ Drug/Alcohol _____

☐ HIV test results _____

This Authorization shall become effective immediately and shall remain in effect :

☐ Six months from date of signing ☐ Other (specify) _____

Completion of this document and acknowledgement of the back of this document authorizes disclosure and/or use of my medical information. READ BEFORE SIGNING.

PATIENT SIGNATURE: _____ DATE: _____

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

_____

If more than 10pgs, Do Not FAX. Thank You Mail