Chino Hills Family
Medical Group

Authorization to Release Protected Health Information

Patient's Name: _____

Date of Birth: _____ SS(optional): _____ Phone: _____

Release From: _____

Phone: _____ Fax: _____

Release to:

Chino Hills Family Medical Center
15361 Central Ave.
Chino, CA 91710
Fax: 909-393-7676 Phone: 909-393-7171
(Fax is the preferred option.)

Reason for release:

_____ Transfer of Medical Care
_____ Legal
_____ Claim for Reimbursement
_____ Other _____

Specified information to be released:

Dates of Treatment: _____ (if "ALL" please indicate)

_____Health Summary
_____EKG/Diagnostics/Radiology reports/results
_____Hospital Records
_____Immunization Records
_____Labs
_____Consult Notes
_____Operative Report
_____Other _____

I understand that the information disclosed may contain testing or treatment information relation to Mental Health, Drug and/or Alcohol Abuse Treatment, Sexually Transmitted infections, HIV/AIDS virus.

I understand that once the information is disclosed, the information is subject to re-disclosure and may no longer be protected by the federal privacy regulation.

I understand that this form may be revoked at any time providing the information has not already been disclosed. I may revoke authorization by notifying CHFMG in writing, Attn: Privacy Officer.

I understand that refusal to sign this authorization does not condition treatment.

This authorization is valid for 30 days from the signature date of release.

Signature of Patient: _____ DATE: _____

Signature of Other Authorized Person: _____ DATE: _____

Relationship to Patient: _____