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## ***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 Group***

***15361 Central Ave.***

***Chino, CA 91710***

***Fax: 909-393-7676 Phone: 909-393-7171***

***Email: chfmg@chfmg.com***

**Reason for release:**

\_\_\_\_\_ Transfer of Medical Care \_\_\_\_\_ Claim for Reimbursement

\_\_\_\_\_ Legal \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specified information to be released:**

**Dates of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if “ALL” please indicate)**

\_\_\_\_\_Health Summary \_\_\_\_\_Labs

\_\_\_\_\_EKG/Diagnostics/Radiology reports/results \_\_\_\_\_Consult Notes

\_\_\_\_\_Hospital Records \_\_\_\_\_Operative Report

\_\_\_\_\_Immunization Records \_\_\_\_\_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 1 year from the signature date of release.**

**Signature of Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Other Authorized Person:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_