SOUTH COAST MEDICAL GROUP
FAMILY PRACTICE OC URGENT CARE

5 JOURNEY STE . 130, ALISO VIEJO, CA 92656
949-360-1069 949-389-8968

PERMISSION TO RELEASE MEDICAL RECORDS AND MEDICAL INFORMATION

Patient Name: _____ **Other Names Used:** _____

Date of Birth: _____ **Last four digit SSN:** _____

1 - Purpose of Release Request:

☐ **Insurance** ☐ **Attorney** ☐ **Doctor** ☐ **Personal** ☐ **Other:** _____

2 - Type of General Medical Information to be Released:

☐ _____ To Present

☐ Discharge Summary ☐ ER Record ☐ Progress Notes ☐ HIV testing
☐ Discharge Instructions ☐ X-Rays Reports ☐ Medication Records
☐ History and Physical ☐ Lab Reports ☐ Doctor's Orders
☐ Consultations ☐ EKG/ECG Tests ☐ Treatment Plans
☐ Operative Report ☐ Therapy Notes ☐ Commitment Papers

Other (please specify): _____

3 - I specifically authorize the discloser of the following information

☐ Mental Health Information ☐ Drug / Alcohol Condition ☐ HIV / AIDS Information ☐ Genetic Information

4 - I authorize the information designated above to be released from

Facility Name: _____

Street Address: _____

City / State / Zip: _____

5 - I authorize the information designated above to be released to:

Facility Name: _____

Street Address: _____

City / State / Zip: _____

6 - Expiration of Authorization of Release:

This authorization is valid for 90 days from the date of the authorization or until (specify date) ___/___/___ unless revoked by the patient orally or in writing at an earlier time.

7 - Discloser & Authorization Signature

I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive health care services or reimbersment for services except in the circumstance that the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that discloser.

8 - Right to Revoke

I understand I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I also understand that revoking this authorization will not apply to any information released by this facility before they received the revoction. I have a right to receive a copy of this authorization. I Understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by recipient without the knowledge or consent of my self at which time it may no longer be protected under privacy law. However, I also undestand that federal and state law may restrict re-discloser of HIV/AIDS information, Mental Health infrmation, Drug/ Alcohol conditions, or Genetic information.

Signature of patient (or legally responsible person) **Date**