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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: _____ **DATE:** _____

FAX: _____ **PHONE:** _____

PLEASE FORWARD THE FOLLOWING MEDICAL RECORDS FOR:

PATIENT:_____ _____ **DATE OF BIRTH:** _____
First Name *Last Name* *Middle Initial*

- ☐ Complete Medical Record
- ☐ Partial Medical Record:
  - ☐ Physician Consultation/Progress Notes
  - ☐ Pathology Reports
  - ☐ Labs
  - ☐ Diagnostic Reports (X-Ray, U/S, CT, MRI, etc)
  - ☐ Other _____
- ☐ Treatment Records
- ☐ Billing Records
- ☐ Dates of Service:_____

By signing below, I authorize the use or disclosure of my Protected Health Information as described above. I understand that: I have a right to a copy of my medical records from my physician(s) upon my request; I have a right to see a copy of the information described on this authorization form in accordance with DVO's record access policies; I can, upon written request to DVO, revoke this authorization at any time, except to the extent that DVO has already taken action based upon my authorization; and I have a right to receive a copy of this form after I have signed it. I acknowledge that I have read and accept all of the above.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Personal Representative's Authority

If you have any questions, please call our Medical Records Department at 925-677-5041, ext. 212
THANK YOU!

FOR INTERNAL USE ONLY:
Request Completed By: Date of Request: Payment Received: $

Requested Via: ☐ Mail ☐ Fax (# _____) ☐ Phone-Spoke w/ _____ Date/Time:_____

ShareFolder Filename: PATIENT FORMS\Records Release Fax –Signature Form.doc Rev: 12/11/2017