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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

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