Request of Medical Information

1. Authorization: I authorize disclosure of medical information and health records as described below:

Name of Patient:_____ Date of Birth_____

Patient Address: _____

Social Security Number:_____-_____-_____ Telephone (_____)_____
(Optional)

2. Record Holder:__Release of Information Citrus Valley Medical Associates_____

_2250 S. Main St. Suite 106___Corona_____California_____92882_____
Street Address City State Zip

Telephone: (951) 256-3799 **Fax: (951) 817-0362**

3. Records May Be Released TO: _____
(Hospital, Medical Group or other Service Provider)

_____
Street Address City State Zip

Telephone: (__) __-_____ **Fax: (__) __-_____**

4. Type of Information: This authorization is limited to the following type(s) of information indicated below. **Please initial all that apply.**

____Discharge Summary
____Progress Notes
____Doctor's Orders
____History/Physical Exam
____Consultation Reports
____Emergency Department Reports
____Laboratory Tests
____Any & All Records
____Other (Please Specify)_____

____Treatment for Alcohol and/or Drug Abuse
____HIV Test Results (Human Immunodeficiency Virus)
____Psychiatric Records
____Billing Information
____Radiology/Nuclear Medicine Reports
____Operative/Procedure Reports

5. Dates of Service: From_____/_____/_____ To_____/_____/_____

6. Use of Information: The individual or entity identified above is permitted to use my information for the following purposes: **Please initial all that apply.**

___Transfer of Care ___Second Opinion ___Personal ___Insurance ___Legal
___Continuing of Care

___Other (please specify)_____

7. Duration: This Authorization is valid for one year from the date next to my signature, unless otherwise noted here:_____

8. Additional Copy: I further understand that I have a right to receive a copy of this authorization upon my request.

9. Redisclosure: I understand that once received, my records will be subject to re-disclosure and may no longer be protected by federal privacy laws.

10: Revocation: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requester is specifically required or permitted by law.

11. Explanation: I understand that my treatment is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.

12. Signature:

Printed Name:_____

Signature:_____Date/Time:_____

If signed by someone other than patient, indicate relationship to patient: _____

Witness Signature:_____Date/Time:_____

(**NOTE*: LEGAL DOCUMENTATION ALONG WITH AN ID MUST BE PROVIDED TO PROVE AUTHORITY TO SIGN ON THE PATIENTS BEHLF.)***

*******Prepayment of fees with completed form is required*******

For Clerical Use Only Payment Received: **Amount:** $_____

□ **Check No**._____ □ **Cash**

□**Credit Card** □ **MC** □ **VISA** □**AMEX Card #** _____

Ex Date: ___/_____/_____ **Security Code#** _____

Name of Card _____

Received by: _____