RELEASE OF MEDICAL RECORDS TO ANTI-AGING & WELLNESS CENTER

AUTHORIZATION FOR USE & / OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
MEDICO-LEGAL FORM

Patient Full Name ____________________________________ MR # / ACCT # ____________________
Address____
City/State/Zip ____SS# ____________________
Phone #: ____________________ Date of Birth ________________Date of Request _________________

I authorize Name of Provider Organization/Person: ____
Address: ____
City/State/Zip____ Phone #: ______________________
Fax #: ________________________

To release information to: Anti-Aging & Wellness Center / Dr. Valerie Phillips ND
Comprehensive Care for Women
276 S. Mill St, Ste C, Tehachapi, CA 93561
O: 661-822-5811 F: 661-822-5828
support@comprehensivecareforwomen.com

Purpose of Request for Information: ( ) Continuing Healthcare ( ) Consultation ( ) Insurance ( ) Personal ( ) Legal ( ) Other (specify): ___________________________________
Information to be Released:
____ (INITIAL) ONLY 2 YEARS OF THE FOLLOWING RECORDS: (X) RECENT OFFICE NOTES (X) CONSULTATIONS (X) LABORATORY: 2 RECENT SETS (X) OTHER TESTS INCLUDING X-RAY, CT, MRI, ETC (X) H&P, DISCHARGE SUMMARY & OPERATIVE NOTE ( ) OTHER ______________

I UNDERSTAND THAT

- My right to healthcare is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address above, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- A recipient of medical information in California may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclose is specifically required or permitted by law.
- Other Health Providers may charge for photocopying patient records in accordance with Health and Safety Code 1755 and HIPAA rules and regulations. Patient agrees to pay any appropriate charges.
- AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution.

________________________________ ___________________
Signature of Patient (or Guardian) Date

________________________________ ___________________
Print Name of Patient (or Guardian) Relationship to patient