Gilroy Family Medical Group

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Smitha Kumar, M.D. **Delie Sakai, M.D.**

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION

PATIENT NAME _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ TELEPHONE NUMBER _____

I hereby authorize _____
NAME OF PHYSICIAN, MEDICAL GROUP, HOSPITAL OR OTHER HEALTH CARE PROVIDER

To furnish medical record information to:

Name and Address _____

Information to be released is limited as follows: _____

This authorization includes _____ (INITIALS) HIV Information _____ (INITIALS) Drug/Alcohol Information _____ (INITIALS) Mental Health Information

The records are being released for the purpose of: _____

☐ Continuing Care ☐ Insurance Changes ☐ Residence Relocation ☐ Patient Access

NOTE: There is a $15.00 non-refuncable fee payable in advance for clerical services and 25¢ per page for PATIENT'S ACCESS RECORDS

☐ Other _____

Duration: This authorization expires on _____ or 6 months from the date signed or revoked earlier in writing.

Additional copy: I further understand that I have aright ot receive a copy of this authorization form upon my request.

Restrictions: I understand that the requestor may not further use or disclose this medical information unless another authorization is obtained from me, unless such disclosure is specifically required or permitted by law.

Date _____ Signature _____

Relationship, if signed by other than the patient _____ Witness: _____

Copy requested ☐ NO ☐ YES Received by (initials) _____