AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

I voluntarily authorize the health care provider named below to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis including x-rays, correspondence and/or medical records including those from my other healthcare providers that the below named health care provider may hold, by means of mail or fax.

Health Provider to Release Records:

Provider: _____

Physician: _____

Phone: _____ Fax: _____

Address: _____

Health Providers Listed Above to Release Records To (choose one):

___ Patient will pick up

___ FiCAREMed | Phone: (858) 485-5111 | Fax: (858) 485-6747 15644 Pomerado Road, Suite 100, Poway, CA 92064

Health Providers Listed Above to Release (choose one):

___ All medical records

___ Medical records with the following exception(s)

_____

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. I understand that I have a right to receive a copy of this authorization. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above. This authorization will remain in effect for one year from the date that it is signed.

Signature:_____ Date:_____

Print Name:_____ Relationship to Patient: _____