Integrated Psychiatric & Medical Care
Diligence Care

Authorization to Release Medical Information

Patient Name: …….
Date of Birth: ……
Phone Number: ……

I hereby authorize (former physician's office or specialist or health care provider or treatment/testing provider) …….. to disclose my health records to (recipient of medical records)
……
for continuation of my medical care.

- ○ Entire Record
- ○ Specific Information:
  ……
  ……
  ……
- ○ All Mental Health Records [(45 C.F.R. 8 164.501) except psychotherapy notes]
- ○ Other:
  ……
  ……
  ……

Please send the medical record information to:

Physician's Name: ……..
Phone Number: ……
Address:
……
……
Fax Number: ……

This form is to allow the use of your medical information. It follows the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 and Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on authorization. **Unless otherwise revoked, this authorization will expire 90 days from the date the authorization was signed**. The facility, its employees, and physicians are hereby release from legal responsibility or liability from disclosure of the above information to the extent indicated and authorized herein.

PATIENT SIGNATURE: ……. DATE: ……

LEGAL GUARDIAN: …… DATE: ……