

AUTHORIZATION FOR USE / DISCLOSURE OF HEALTH INFORMATION

This authorization allows Rocklin Family Practice & Sports Medicine and its physicians to release confidential medical information and records on my behalf. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

To release information regarding my: (initial the following)

- | | |
|--|---|
| <input type="checkbox"/> Appointment dates & times | <input type="checkbox"/> Diagnosis or prognosis |
| <input type="checkbox"/> Reason for appointments | <input type="checkbox"/> Test results (lab, pathology, radiology, etc.) |
| <input type="checkbox"/> Medical history | <input type="checkbox"/> Correspondence |
| <input type="checkbox"/> Illness or injury | <input type="checkbox"/> All billing information |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Referrals and authorizations |
| <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Durable Medical Equipment |
| <input type="checkbox"/> Treatment (including coverage and benefits) | <input type="checkbox"/> ALL OF THE ABOVE |

TO: _____ Relation to patient: _____

I do consent to the specific release of the following records. I understand that the following information cannot be released without my specific consent.

- | | |
|--|---|
| Drug/alcohol/substance Abuse _____ (initial) | HIV Diagnosis/Treatment _____ (initial) |
| Psychiatric/Mental Health _____ (initial) | Genetic Information _____ (initial) |
| Test for antibodies to HIV _____ (initial) | |

DURATION: This authorization shall be effective from the following dates: _____ to _____

RESTRICTIONS: 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. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

Signature of patient *or legal guardian*

Relationship *if other than patient*

Patient's Name (**Print please**)

Date

Patient's Date of Birth