Rocklin Family Practice and Sports Medicine
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Medical Records Release Form

This authorization allows healthcare provider(s) named below to release confidential medical information and record. Note: information and records regarding treatment of minors HIV, psychiatric/mental health conditions or alcohol/substance abuse have special rules that require specific authorization.

Print name of Patient _____

Date of Birth: _____/_____/_____ SSN: _____

My Authorization

I here by authorize _____ _____

Physician/Healthcare Facility Phone Number

_____ _____ _____ _____

Address City State Zip Code

To use or disclose the following health information

☐ All of my health information (unlimited)

☐ My health information relating to the following treatment or condition (limited)

_____

My health information covering the period from ____/_____ (Date) to ____/_____ (Date)

I also consent to the specific release of the following records (initial for consent)

Drug/alcohol/substance abuse _____ Psychiatric/mental health _____

Test for antibodies to HIV _____ HIV diagnosis /Treatment _____

Genetic information _____

The above party may disclose this health information to the following recipient:

Name or title of organization _____

Address _____ City _____ Zip Code _____ State_____

Email _____

Phone _____ Fax number _____

This authorization ends (date) _____/_____/_____

Signature _____ **Date _____/_____/_____**