Rocklin Family Practice and Sports Medicine
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Lincoln 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** ______/_______/________