

Date: _____

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

SSN: _____

I hereby authorize _____ to disclose/release the following information (check all applicable):

- | | |
|---|--|
| <input type="checkbox"/> All records | <input type="checkbox"/> Billing records |
| <input type="checkbox"/> Laboratory/pathology records | <input type="checkbox"/> Pharmacy/prescription records |
| <input type="checkbox"/> X-ray/radiology records | <input type="checkbox"/> Other (Please Describe) _____ |

These records are for services provided on the following date(s): _____

Facility supplying the records:

Name: _____

Address: _____

Phone: _____

Fax: _____

Signing This Authorization is Not a Condition of Treatment

- ✓ I understand that Drs. Scott, Hsieh & Murphy will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- ✓ I understand that I may be required to sign an authorization if my treatment is provided solely for the purpose of created protected health information for disclosure to a third party.
- ✓ If applicable, I understand that the treatment being provided by Drs. Scott, Hsieh & Murphy is related to research and that my authorization of disclosures for research related purposes, is a condition of this treatment. I understand that if I do not sign this authorization, then Drs. Scott, Hsieh & Murphy will not provide research related treatment to me.

Please check:

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

When form is completed, please mail or fax to:

**ATTN: Medical Records
1776 Ygnacio Valley Road, Suite 210
Walnut Creek, CA 94598
Fax: (925) 933-4460**

Printed Name

Signature of patient or guardian

You have the right to revoke this authorization by sending your written request to the address listed above.