CUCAMONGA VALLEY™
MEDICAL GROUP

Authorization to Release or Receive Medical Records

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Privacy Act:

PATIENT'S FIRST AND LAST NAME _____ SOCIAL SECURITY NUMBER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ CELL _____ BIRTHDATE _____

I hereby authorize (those named below):

NAME OF PHYSICIAN / PROVIDER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

to furnish to (those named below):

NAME OF PHYSICIAN / PROVIDER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of the following information from service dates _____ to _____

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed the NOPP of this healthcare facility and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize this Healthcare Facility to use and disclose verbally, by mail, fax, encrypted or unencrypted email, the following types of super-confidential information as stated in the NOPP.

Initial where appropriate:

_____ INITIALS HIV records (including HIV test results) and sexually transmissible deseases

_____ INITIALS Psychotherapy records / this serves as my signature release under Federal Law

_____ INITIALS Alcohol and substance abuse diagnosis and treatment records

_____ INITIALS Other / Specify: _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____