AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____

Address: _____

Patient: _____ Date of Birth: _____

SSN#: _____ ID#: _____

I, _____ request the following information:

☐ X-rays ☐ History ☐ Records ☐ Diagnosis ☐ Treatment ☐ Reports ☐ Billings

Concerning my: ☐ Accident ☐ Injury ☐ Illness ☐ Other _____

To be released to:

☐ 701 Howe Avenue, Suite C5
Sacramento, CA 95825
Phone: (916) 972-1100
Fax: (916) 972-1615

☐ 2485 Sunrise Blvd. Suite A
Rancho Cordova, CA 95670
Phone: (916) 281-2251
Fax# (916) 281-2252

☐ 5255 Elkhorn Blvd.
Sacramento, CA 95842
Phone: (916) 334-1100
Fax: (916) 334-1105

☐ 2469 Rio Linda Blvd., Suite A
Sacramento, CA 95815
Phone: (916) 468-1100
Fax: (916) 333-3193

For the purpose of: _____

According to Section 123.110 of The California Health & Safety Code, these records/films must be provided within 15 days of your receipt of this notice.

Signed: _____

☐ Patient ☐ Spouse ☐ Parent ☐ Guardian

PROTECTED HEALTH INFORMATION

The medical information in this AUTHORIZATION is confidential and protected by both State and Federal Law. It is unlawful for unauthorized persons to review, copy, disclose, or disseminate confidential medical information. If the reader of this warning is not the intended recipient of the intended recipient's agent, you are hereby notified that you have received this AUTHORIZATION in error, please notify us immediately at (916) 972-1100 and either destroy these documents or return the originals by mail. Thank you!