AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name: Last _____ First _____ MI ____ Date of Birth _____

Address _____

SSN # _____

I authorize:
(Person or facility which has health information)

Name: _____

Address Street _____

City, State, Zip _____

Phone # _____ Fax # _____

To release health information to:

El Camino Medical Clinic
1828 El camino Real, Suite 706
Burlingame, CA 94010
Phone: 650-777-9117 Fax: 650-860-3269

Information to be Disclosed

- ☐ Standard Chart Copy
  Physician Dictated Reports, All Test Results and Demographic Face Sheet
- ☐ Hitory and Physical
- ☐ Other _____
- ☐ Entire Record
- ☐ Discharge Summary
- ☐ Labs and Imaging Reports
- ☐ EKG
- ☐ Operative Report
- ☐ Pathology Report

I understand the information in my health record may include information relating to sexually transmitted disease, HIV or AIDS, behavioral or mental health services, or treatment for alcohol and drug abuse.

YOUR RIGHTS: This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

Signaturature _____ Date _____

Print Form