PENINSULA NATURAL HEALTH CENTER

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MEDICAL RECORDS RELEASE & STATEMENT OF CONFIDENTIALITY

NAME (last, first, m.) _____ DATE OF BIRTH ___/___/___

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

( ) _____ HOME PHONE ( ) _____ ALTERNATE PHONE _____ SOCIAL SECURITY NUMBER

I authorize _____
NAME OF PHYSICIAN, CLINIC OR HOSPITAL

to release the folowing medical information ☐ **chart notes** ☐ **labs** ☐ **imaging studies** ☐ **hospital reports** ☐ **history** ☐ **other**

to this physician at Peninsula Natural Health Center: ☐ **Dr. Anna Colombini** ☐ **Dr. Steven Davis**

This authorization covers my care given from ___/___/___ DATE **to** ___/___/___ DATE

This information is being released for the following purpose: ☐ **continuing medical care** ☐ **insurance billing** ☐ **other** _____ PLEASE SPECIFY

I authorize _____ NAME , _____ RELATIONSHIP

to pick up the above records.

I may revoke this authorization at any time by notifying Peninsula Natural Health Center or other authorized health care providers or clinics in writing. I agree that a photocopy of this authorization may be considered a valid authorization.

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I release the health care provider(s) and their staff from all legal responsibility or liability that may arise from the release of this information.

This consent and release expires 120 days from the date below.

I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment. I understand that revocation will not apply to information that has already been released in response to this authorization. Additionally, I realize that there is potential for my confidential information to be redisclosed by the recipient and thus it would no longer be protected under this privacy rule.

_____ SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____ DATE

_____ RELATIONSHIP (if other than the patient) ( ) _____ TELEPHONE NUMBER