

**HEALTH INFORMATION SERVICES  
AUTHORIZATION TO RELEASE INFORMATION**

Patient's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_ Ph: ( ) \_\_\_\_\_

I am requesting my records **FROM:** \_\_\_\_\_  
Name, Address, City, State, Zip

Please release my records **TO:** \_\_\_\_\_  
Name, Address, City, State, Zip

**Duration:** This authorization is valid until \_\_\_\_\_, or one year from time of signature.  
(Date)

**Revocation:** This authorization is also subject to written revocation by the undersigned at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing patient or others have acted in reliance upon this authorization.

**Redisclosure:** I understand that the recipient may not lawfully further use or disclose this health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**Description of and/or limitation on information to be disclosed:**

\_\_\_ ALL OF MY MEDICAL RECORDS.

\_\_\_ ONLY THE FOLLOWING INFORMATION: \_\_\_\_\_

\_\_\_ RADIOLOGY FILMS/DISC: \_\_\_\_\_ EXAM/DATE \_\_\_\_\_

\*Fee is \$15.00 per CD disc or \$5.25 per sheet of film

\_\_\_ Drug/Alcohol Information (please sign): \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_ HIV Blood Test Results (please sign): \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_ Psychological Reports (please sign): \_\_\_\_\_ Date \_\_\_\_\_

**Purpose of disclosure:** \_\_\_\_\_

My signature authorizes the release of information indicated above.

I will be charged **\$0.25 per page for 1-100 pgs. & \$0.15 per page thereafter** by HealthPort, the inhouse copy service used by SRMF. Please allow **10 – 15 days** for our office to process the request.

**I have the right to receive a copy of this authorization**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **Relationship** \_\_\_\_\_

Patients 18 years or older must sign authorization. Proof of Guardianship/DPA must be submitted with authorization. Parent or Legal Guardian must sign for anyone under 18 years of age.

Legal Clerks:	Phone:	Fax Number:	Address: <b>SRMF</b>
Irma Barajas Lani Duran	707-436-2516	707-399-9505	<b>2720 Low Court Fairfield, CA 94534</b>