Integrated MD Care

AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL INFORMATION

Explanation:

This authorization to receive or release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56, et seq., California Civil Code.

Clinical Summary
Current History and Physical
Discharge Summary
Laboratory and Diagnostic Reports
Pathology Reports
Consultation Reports
Mental Health/Psych Reports
Operative Reports

Duration:

This authorization shall become effective immediately and shall remain in effect until the request is rescinded in writing.

Restriction:

I understand that the requestor may not further use or release the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Additional Copy:

I understand that I have a right to receive a copy of this authorization upon my request.

Patient's Name*

Date of Birth*

Signature of patient or Responsible Party*

Relationship to Patient*

Date*