My Family Medical Group

5475 Walnut Ave | Chino, CA 91710 | (909) 591-6446 | www.MyFamilyMG.com

Consent for Release of Medical Information

I hereby authorize the Practice, or any of its employees, staff, or agents, to use and disclose protected health information (PHI) from the medical record(s) of:

Patient name:			
Address:			
(Street)	(City)	(State)	(ZIP)
Date of birth:	Medical record #:		

REQUESTING RECORDS FROM:	**WHERE TO SEND THE RECORDS TO:**
Name/Facility:	Name/Facility:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone Number:	Phone Number:
Fax Number:	Fax Number:

Please Send Records from the following date range: From: To:

Initial all that apply:

I consent to have all the medical information regarding my treatment or hospitalization from my:

_____ Drug and alcohol treatment care

_____Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*

_____ Psychiatric care

**requires special consent*

I am requesting the following information to be released**:**

_____ Abstract of record (includes: history and physical, operative reports, consultations, discharge summaries, laboratory findings, radiology reports, and other significant findings)

_____ Entire medical record

_____Other: ______Labs _____Slides** _____X-rays**

***I am aware that there are separate fees for and consents for X-rays, slides, and medical records, etc.*

Purpose of Requested Use or Disclosure		
Transfer of Care	Patient Request	Insurance
Legal	Continuing Care	Other

Patient Access to Records Fee: My Family Medical Group receive the right to charge the fee schedule as set by California (CFR 164.524). By signing this authorization, you are **agreeing to pay for you to receive your records**. In the case of continuity of care, we may transfer a minimal portion of your records directly to a physician as a courtesy one time only.

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_____ Litigation for review

_____ Insurance (company name):

_____ Other (specify reason):

This consent permits the Practice to use and disclose my protected health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of protected health information is described in the Practice's notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, the Practice is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the Practice, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

Print patient's name: ____

Signature of patient: ____ Date: ____________________

Signature of legally authorized person: ____