TRI-CITY HealthCenter
Our Community. Your Health.

Release of Medical Information Authorization

Patient Name: _____ **Date of Birth:** _____

Patient Chart Number: _____

IF REQUESTOR IS NOT PATIENT:

Requestor Name: _____

Requestor Relationship to Patient: _____

I AUTHORIZE TRI-CITY HEALTH CENTER TO (check one box):

☐ Send a copy of my Medical Information to: OR ☐ Obtain my Medical Information from

Name of Physician, Health Care Facility or Provider: _____

Address: _____

Phone Number: _____ Fax Number: _____

SPECIFY THE MEDICAL RECORDS INFORMATION TO INCLUDE:

☐ Medical Records, Dated From _____ to _____

☐ Lab Results, Dated From _____ to _____

☐ X-Ray Report

☐ Immunizations

NOTE: Medical records may include information related to mental health, alcohol/drug and HIV references. The actual treatment records from mental health and/or results of HIV tests will not be disclosed unless specifically requested below.

☐ Behavioral/Mental Health Information (patient initials ____)

☐ Result of HIV Blood Test (patient initials ____)

☐ Alcohol/Drug Abuse (patient initials _____)

☐ OTHER (Specify): _____

With the Following Restrictions (Please Explain in Detail): _____

The information may be used for the following purposes:

☐ Patient Care
☐ Insurance or Legal Claim
☐ Personal
☐ Other (Specify): _____

This Authorization will automatically expire one (1) year from the date signed or on date: _____
(unless revoked earlier in writing)

MEDIA TYPE: (check one)
☐ CD
☐ Paper

DELIVERY PREFERENCE: (check one)
☐ Mail
☐ Fax
☐ Pickup

Please complete signature on other side

MEDICAL RECORDS DEPARTMENT OFFICE
39500 Liberty St., Fremont 94538 Ph: 510-252-5848 Fax: 510-770-8141

I understand that I have a right to receive a copy of this Authorization. I understand that there is a fee to obtain medical records except when copies are sent directly to a physician or health care provider.

SIGNATURES:

PATIENT/REPRESENTATIVE	DATE
TREATING PHYSICIAN/PROVIDER*	DATE

*For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further the LPS act often requires that both patient's treating physician/provider and the patient sign the authorization form before information is release.