Authorization to Disclose Health Information

Patient Name ____ Telephone Number ___________________

Address ____

Date of Birth ________________________

I hereby authorize: Dr.Vogus or representative to review, make copies of and release my medical information to:

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1. The type and amount of information to be used or disclosed is as follows:

_____ Entire Record

_____ Most Recent History and Physical from (date) ______________ to (date) ______________

_____ Discharge Summary from (date) ______________ to (date) ______________

_____ Laboratory Results from (date) ______________ to (date) ______________

_____ Consultation Reports from (date) ______________ to (date) ______________

_____ Other ____

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2. I understand and herby also consent to the release of any and all alcohol and or drug abuse information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or psychiatric treatment records under the same conditions outlined above. I understand that such information cannot be released without my specific consent.

Signed ____ Date ___________________

3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _______________________. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

____ Date __________________________
Signature of Patient or legal representative (state relationship if not patient)

I am aware there will be a charge for this service as governed by the California Health and Safety Code #123110

All copying & billing will be done by Professional Medical Copy;
2700 Eureka Way, Redding, CA 96001 (530) 241-2971 Fax (530) 241-6928.
Charges for medical record copying as governed by California Health & Safety Code #123110
$6.25 clerical fee / .25 per page / shipping and handling