ALTA CALIFORNIA MEDICAL GROUP
2925 N. Sycamore Dr., #204, 205
Simi Valley, CA 93065
(805) 578-9620 Fax (805) 583-1937

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By this written authorization I permit _____ to release information regarding my:

( ) Medical Information Record
( ) Psychiatric Health Record
( ) Chemical/Alcohol Treatment Record
(HIV information requires additional consent)

_____
Patient Name (Please Print) Date of Birth

_____
Address including zip code

_____
Telephone Number

Information is being requested from: _____
Name of Practitioner

_____
Complete address with street number, street name, city, state and zip code

_____ _____
Telephone number with area code Fax number with area code

I am requesting the disclosure of this information for the following purpose:

( ) Transfer of records from previous physician to a new physician.
( ) Review of records by a consultant.
( ) Other: _____

Release two years of medical records information unless specified below. Specify specialty, dates or sections of the medical record you wish copied: _____

This authorization is effective from the date following my signature and shall terminate one year from that date. I understand that I have a right to receive a copy of this authorization. I wish a copy of this authorization: ( ) Yes ( ) No

_____ _____ _____
Signature of Patient or Legal Guardian Date Relationship if not patient

_____ _____
Signature of Witness of above Signature Date

INFORMATION TO ACCOMPANY A RELEASE OF MEDICAL RECORDS / INFORMATION

Everyone in the Medical Records Department here at Alta California Medical Group hope that this Medical Records Release form is not overly confusing. The confidentiality of your medical record is of utmost importance. We want to make sure you understand that we have many office policies to insure confidentiality of your personal medical history. Having you read, understand and sign this form is only one of the steps we take to insure your privacy.

Please be aware of the following:

1) Medical Record request can take up to fifteen (15) calendar days of the receipt of the completed/paid request.
2) Please complete the entire name, address, including zip code, of the physician or medical facility where we will be transferring your records to or requesting your previous or ongoing records from.
3) A member of our staff who has signed a confidentiality statement copies medical records.
4) If the records are being sent to another physician or medical group, the fee per patient for copying medical records is $20.00 for up to 100 pages. If your family is moving and the records requested are for a brief period of time, we can arrange a discount. If the requested record(s) exceeds 100 pages, you will be charged 25 cents per page. The fee needs to be paid in advance of the records being transferred.
5) Two years of medical information will be copied, unless specific information is requested. Please be sure to indicate specific request on the reverse side of this form.
6) Please notify our Medical Records staff of any urgent medical request you may have and the reason for such a request.
7) A faxed Authorization for Release of Medical Records is deemed to have the same force as the original document. A Medical Records staffer will verify your signature against that on the medical record.
8) Your physician or therapist has the right to offer you a chart summary in lieu of Medical Records.
9) The practitioner may deny Psychiatric and Drug Abuse records for specific reasons.
10) If you should have any disagreement with any of the information stated above, please contact our office manager as soon as possible, so that any delays can be avoided.

THANK YOU FOR YOUR COOPERATION,
THE MEDICAL RECORDS STAFF

I have read and understand the statements offered above, and concur with the information as stated.

_____ _____ _____
Signature of patient/legal guardian Relationship, if not the patient Date

_____ _____
Signature of witness Date

For Office Use Only. Any differences in the statements offered above or reasons for denial of medical records are noted as follows:_____

_____

_____