

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Birth Date _____

Information to be released **From:**
Visalia Women’s Specialty Medical Group
1700 S. Court Street, Suite B
Visalia, CA 93277
Phone 559-741-1202 Fax 559-741-0123

Information to be released **To:**
Name/Agency: _____
Address: _____
Phone: _____

Purpose and limitations for release: on-going medical care or _____
Information to be released:

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires in 1 year or on _____. I realize that this is a required authorization and that I must voluntarily and knowingly sign this authorization before any records can be released, and that I may refuse to sign, but in that event, the records will not be released. I understand that information used or disclosed pursuant to this authorization, maybe subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations. I release my physicians, the clinic/hospital, school or other entity as identified above, and their employees from any liability arising from the release of information to Dr. Boone or Visalia Women’s Specialty.

I have a right to receive a copy of this authorization, and I will ask for a copy if so desired.
Copy received _____

Signature of Patient _____ Date _____

Signature of Parent or Guardian _____ Date _____
Relationship to patient _____