

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Information to be released **from**:

Name/Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Information to be released **to**:

\_\_\_\_\_ at

**Visalia Women's Specialty Medical Group**

**1700 S. Court Street, Suite B**

**Visalia, CA 93277**

**Phone 559-741-1202**

**Fax 559-741-0123**

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 \_\_\_\_\_