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:

____

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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 _________________________