Facey
Medical Group

EMRN:
HCL:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

☐ Mission Hills (Central ROI)	11211 Sepulveda Blvd. Suite 120, Mission Hills, CA 91345	(818) 365-9531
☐ Behavioral Medicine	11165 Sepulveda Blvd., Mission Hills, CA 91345	(818) 837-5780
☐ Canyon Country	17909 Soledad Canyon Road, Canyon Country, CA 91387	(661) 250-5200
☐ Copper Hill	27924 Seco Canyon Road, Ste. 101 Santa Clarita, CA 91350	(661) 513-2100
☐ Northridge	18460 Roscoe Blvd., Northridge, CA 91324	(818) 734-3600
☐ Porter Ranch Plaza	19950 Rinaldi St., Northridge, CA 91326	(818) 837-5715
☐ San Gabriel	207 S. Santa Anita St. San Gabriel, Ca. 91775	(626) 576-0800
☐ Simi Valley	2655 First Street Suite 325, Simi Valley, Ca. 93065	(805) 206-2000
☐ Valencia I	26357 McBean Pkwy., Valencia, CA 91355	(661) 222-2600
☐ Valencia II	25775 McBean Pkwy., Valencia, CA 91355	(661) 222-2600
☐ Valencia III	23929 McBean Pkwy., Suite #200, Valencia, CA 91355	(661) 222-2600
☐ Women's Center	11165 Sepulveda Blvd., Mission Hills, CA 91345	(818) 837-5770

Type of access requested: (If selecting more the one (1) option additional charges may vary)
☐Paper copy of records ☐CD Copy ☐Inspection of records (by appointment only *(allow 5 business days)*

I request access as the ☐ Patient ☐ Parent/Guardian ☐ Medical Power of Attorney *(Proof of legal documentation is required)*

Name of Patient (*Please print clearly*) _____ AKA _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____ Telephone (___)_____

Please **SEND** medical information **TO:** (☐*If same as above)*	Please **REQUEST** medical information **FROM:**
Name of Person or Entity to Receive Information	Name of Medical Office/Provider
Street Address	Street Address
City, State and Zip Code	City, State and Zip Code
Telephone	Telephone

Duration: This authorization will expire 12 months from the date signed.

Revocation Process: I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Facey Medical Group.

Rev. 01/31/2011

SEND TO: Scan under ROI/Legal*
REQUEST FROM: Scan under Outside Records*

Right to Copy: I have a right to receive a copy of the Authorization after I sign it.

Re-Disclosure Statement: I understand that once Facey Medical Group discloses my health information to the recipient, Facey Medical Group cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.

SPECIFY RECORDS TO BE RELEASED
(Check the box and initial which type of information is to be released)

☐ All General Medical Information (from _____ to _____). General medical records may include information of diagnosis and / or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

☐ Information regarding specific injury or treatment (from _____ to _____)

☐ X-Ray (*check one or both*): (from _____ to _____) ☐ Reports ☐ Films ($18.00 per slide)

☐ Laboratory results (from _____ to _____)

☐ Mental health Only (from _____ to _____) _____
(Psychotherapy sessions) Signature of Patient or Patient's Representative

☐ Other (Specify): _____

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Facey Medical Group to use or disclose my health information in the manner described above.

_____ _____ _____
Date Signature of Patient or Representative Indicate Relationship (if not signed by patient)

☐Mail ☐Pick up ☐ Pick up at Facey Location _____ ☐ I give permission to _____ to pick up *(ID verification is required for all pick up requests)*

OFFICE USE ONLY

Request processed by: _____ / _____ Date: _____
Approved by(Please print and sign)

If denied state reason why: _____

_____ / _____ Date: _____
Denied by (Please print and sign)

Incoming Records Name of Provider: _____ Date: _____

Reviewed by MD/Practitioner: _____

Bactes Use Only (Bactes copied date stamp) ⟶

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