Patient Name:

Record #:

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize: ____________________

____

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to disclose records obtained in the course of my evaluation and/or treatment to:
(Please provide complete address)

____

____

____

For purpose of: ____________________

I understand that I have the right to limit the type of information released. If I choose to limit the information released, I understand that it may be necessary for Scripps to inform the requestor that portions of the record have been withheld.

Unless otherwise indicated below, my signature authorizes the release of all medical records without exception, including any information concerning HIV testing, psychological or psychiatric treatment, and/or alcohol or drug abuse.

____

____

This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken, and if not earlier revoked, this consent shall become invalid one year from the date of signature.

I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above.

(THE CLINIC RESERVES THE RIGHT TO CHARGE FOR COPIES OF MEDICAL RECORDS)

Copy of this form requested and received: ☐ Yes ☐ No

Patient's PRINTED Name: ____________________ Phone: ____________________

Patient's Birthdate: ____________________ Soc. Sec. #: ____________________

SIGNED: ____________________ Date: ____________________

*Signature of Patient / Spouse / Parent / Guardian / Conservator / Patient's Legal Representative

If signed by other than patient, indicate relationship: ____________________

*Authorized representative must submit copies of legal documents supporting assignment of this authority.

IMPORTANT: Information released in accordance with this request is prohibited from further release without patient authorization

55-9007 (Rev. 8/00) WHITE — Medical Record Copy YELLOW — Requestor Copy