Coalinga Regional Medical Center

1191 Phelps Avenue, Coalinga, CA 93210 · (559) 935-6400 · (559) 935-4262 - fax

Authorization for Release of Patient Health Information

Please provide all information requested or this Authorization is not valid. *Please Print.*

$_____ record release fee - Check Enclosed ☐ or Cash paid in person ☐

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone Number: (_____) _____

I hereby authorize Coalinga Regional Medical Center

To Release information from the medical record of _____
(Patient Name) Print

The following information:	*For the following purpose:*
☐ Complete health records	☐ Legal
☐ Records from last ____ year(s), including progress notes, immunizations, lab & x-ray reports, & consult notes.	☐ Insurance
☐ Lab reports - date(s) _____	☐ Patient Request
☐ X-Ray report(s)	☐ Continuation of care
☐ Progress Notes - date(s) _____	☐ Other (please specify) _____
☐ Other (please specify)_____	_____
_____	

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I hereby specifically authorize the release of data and information relating to: (check any that apply)

- ☐ HIV / AIDS related testing
- ☐ Mental Health
- ☐ Chemical Dependency (Drug/Alcohol)

This information may be disclosed to and used by the following individual or organization:

Name: _____

Address: _____

Telephone Number: (_____) _____ Fax Number: (_____) _____

This authorization will be valid for one year from the date it is signed or until _____, whichever is shorter. This authorization may be revoked at any time by notifying the above named provider of information in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Information used and disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

_____
Signature of Patient or Legal Guardian
(Parent/Legal Guardian must sign if patient is a minor)

_____
Relationship to Patient, if not the patient

Date: _____

Office Use Only

Copied by:_____ Date: _____

To be sent ☐

To be picked up ☐ Date: _____

Sent on date:_____