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(951) 461-1070 Fax (951) 461-3449

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

FACILITY RELEASING RECORDS: _____

Phone Number: _____ Fax Number: _____

Please release records to: Rhoda Estrella-Itchon, M.D. Fax: 951-461-3449

INFORMATION TO BE RELEASED:

___ IMMUNIZATION RECORD ONLY
___ALL MEDICAL RECORDS
___LAB/TEST RESULTS
___MEDICATION LIST

REASON RECORDS ARE TO BE DISCLOSED:

___ CONTINUED CARE ___ PERSONAL USE

This authorization will expire after request is fulfilled and shall not extend beyond 180 days from the date of signature.
The recipient of the protected health information under the authorization will not re-disclose the information, except with a written authorization or as specifically required or permitted by law.
The above healthcare provider will not condition the provision of care or the receipt of benefits on the signing of the authorization.
Signing this form is voluntary. The patient or patient's representative has the right to revoke this authorization and the right to inspect/or be given a copy of the material to be disclosed.

I have read these policies and voluntarily authorize and request the disclosure above. I authorize use of a copy (including facsimile) of this form for disclosure as described above.

Patient Name: _____ Date of Birth:_____

Phone Number:_____

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____