Release of Medical Information Form

Completion of this document authorizes the disclosure and/or use of health information about you. Please be sure to provide all information requested. Failure to do so may invalidate this authorization.

Name of Patient: _____

Date of Birth: _____ SSN: _____

Patient Address:_____

City: _____ State: _____ Zip: _____

Phone #: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: Katrina Ramos, LMFT 3700 Lime st. Riverside CA (909) 470-1456

To release to: (Fill out the below listing who Katrina Ramos can talk to)

Covering the period of healthcare from_____to_____

Name: _____

Address:_____

City: _____ State: _____ Zip: _____

Phone #: _____

The following information:
Only the following records or types of health information (mark if yes):

- ☐ Discharge Summary
- ☐ Consultation(s)
- ☐ Summary of treatment and goals
- ☐ Assessment and measurements performed
- ☐ Other _____

I specifically authorize release of the following information (initial as appropriate):

- ☐ Mental health information

_____ HIV test results Sexual Assault
_____ Alcohol/drug information Child Abuse/Neglect

PURPOSE
Purpose of requested use or disclosure: patient request OR other: _____

EXPIRATION
This authorization expires on: _____

MY RIGHTS
I may inspect or obtain a copy of the health information that I am being asked to allow the use of disclosure of. I may revoke this authorization at any time, but I must do so in writing and submit it to: Katrina Ramos, LMFT 3745 McCray St. Riverside CA (909) 470-1456

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization. I have a right to receive a copy of this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such a redisclosure is in some cases not protected by California law and may no longer be protected by federal confidentially law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. Options of Electronic Format: According to HITECH section 13405(e) (1); 42 U.S.C. 17935 (e) (1), you may have your electronic medical records transmitted to you or another entity in electronic format. Please choose which type of format you would like the information to be delivered in and note the receiving entity may not accept records in electronic format: Burn to a CD Paper

SIGNATURE

Date: _____ Time: _____am/pm

Signature: _____
(patient / representative / spouse / financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient.