McHenry Medical Group
1541 Florida Avenue, Suite 200, Modesto, California 95350
Phone 209-577-3388 • Fax 209-544-9428 • Tax ID 26-4290978

Authorization for Release of Protected Health Information

Patient name _____ Date of birth _____ Patient ID _____
(Printed)
I hereby authorize _____
Name of doctor and/or facility

_____
Address City, state, zip Phone

To disclose records obtained in the course of my diagnosis and treatment to:

Name _____ Phone _____
(of receiving party*)
Address _____ Fax _____

City, state, zip _____

Information to be released Treatment dates _____

☐ Complete chart ☐ Surgery reports ☐ History & physical exams
☐ Laboratory results ☐ X-ray reports ☐ X-ray films
☐ Doctor/chart notes ☐ Other _____

Reason for disclosure _____

This authorization shall become effective immediately and shall remain in effect until _____ or until 90 days (maximum) from the date of my signature. I understand that this authorization may be modified or rescinded, but that such modification or rescission will be effective only when submitted in writing. I understand that these records may be copied by McHenry Medical Group or by its contracted copy service, HealthPort, in which case I will be charged a photocopying fee of $0.25 per page, plus postage and handling. I also understand that I have a right to receive a copy of this authorization.

NOTE: Specific authorization must be obtained for release of (a) Mental Health Records, (b) Alcohol and Drug Abuse Records, or (c) HIV-AIDS-related Records. The release of such records is at the discretion of the physician.

* The recipient is prohibited from redisclosing the information without the patient's written permission unless specifically required or allowed by law.

_____ _____
Signature of patient or legal representative (inc description of authority) Date

****** <u>This form is valid only when completed in full by patient</u>. ******