



Physician/Provider/Facility Authorization for Release of Information

CHECK ALL RECORD TYPES THAT APPLY

- | | |
|--|---|
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Diagnostic Images |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Psychiatric | |

PATIENT INFORMATION

Patient Name

Date of Birth

Date of Death (If applicable)

Medical Record Number (If known)

Control Number

I, the undersigned hereby authorize:

Physician/Provider/Facility

Street Address

City

State

Zip Code

Phone Number

Treatment Date(s)

Physician/Provider/Facility

Street Address

City

State

Zip Code

Phone Number

Treatment Date(s)

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Physician/Provider/Facility		
Street Address		
City	State	Zip Code
Phone Number	Treatment Date(s)	

to disclose medical records in the course of my diagnosis and treatment to the **Medical Board of California, Enforcement Program**, a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative and/or criminal proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid for three years from the date of signature. **A copy of this authorization shall be as valid as the original.** I understand that I have the right to receive a copy of this authorization if requested by me. I understand that I have a right to revoke this authorization by sending written notification to the Medical Board of California at the above address. My written revocation will be effective upon receipt by the Medical Board of California but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or healthcare provider and the released information may no longer be protected by federal privacy regulations. I am signing this authorization voluntarily and understand that treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

 Patient Signature - OR - Date

 Legal Representative Name Relationship to Patient

 Legal Representative Signature Date

NOTE: Failure by a physician, podiatrist, or healthcare provider to provide the requested records within 15 days, or a healthcare facility within 30 days, of receipt of this request and authorization may constitute a violation of Section 2225.5 of the Medical Practice Act and may result in further action by the Board.