Temecula Valley Advanced Medicine

38860 Sky Canyon Dr. Bldg. A

Murrieta, Ca 92563

Phone Number: (951)696-2215

Fax Number: (951) 696-2286

Authorization for Release of Medical Information

Patients Name: _____ DOB: _____

Phone Number: (_____) _____

I Hereby Authorize: _____

(Name of Medical Provider)

Address: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

To Release My Information To: _____

(Name of Medical Provider or Self)

Address: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Type of Information to be disclosed, please circle those that apply:

ALL RECORDS **LABS** **X-RAYS** **CHART NOTES/PROGRESS NOTES**

Date(s) of Service Requested: _____

How do you want these records? **(**please circle one) **Mail Out**, **Pick up**, or **Fax**

Exclusions: (To exclude any of the following types of information, please circle)

CHEMICAL DEPENDENCY **MENTAL HEALTH** **HIV**

Reason Information is being requested: _____

I understand that I may revoke this consent at any time, and that this authorization will automatically expire in 6 months from the date of signing. I also agree to any charges that may apply to the copy of my records.

Patients Signature _____ Date_____

REDISCLOSURE: I understand that the requestor may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless the disclosure is specifically permitted by law.