Temecula Valley Advanced Medicine

It is preferred that you drwalter@tvamed.com for record requests

Authorization For Release of Medical Information

Patient Name: _____ DOB: _____

Phone No. : (_____)_____

****

I Hereby Authorize: _____

(Name of Medical Provider)

Address: _____

Phone No. : (_____)_____ Fax No. : (_____)_____

To Release My Information To: _____

(Information to New Provider or Self)

Address: _____

Phone No. : (_____)_____ Fax No. : (_____)_____

Type of Information to be Disclosed, Please circle those that apply:

ALL RECORDS **LABS** **X-Ray** **CHART NOTES**

Dates of Service requested: _____

How do you want these records? Printed for Pick Up ($25) or Faxed to New Provider Free.

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

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

Reason for Information being Requested: _____

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

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

Patient's Signature: _____ Date: _____

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