ID Southern California ID Associates, Inc.

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Authorization for the Release of Medical Information

Patient Name **Telephone** **Date of Birth**

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name **Telephone**

Address **Fax Number**

City **State** **Zip Code** **Country**

The purpose or need for disclosure: ____________________

Date Range of Information to be Released: from ____________ **to** ____________
(month/year) **(month/year)**

Please check specific information to be released:

- ☐ **Outpatient Progress Notes**
- ☐ **History & Physical**
- ☐ **Consultation Reports**
- ☐ **Lab Results**
- ☐ **Radiology Reports**
- ☐ **Other (Please Specify):**____________________

AUTHORIZATION: Permission is hereby granted to *Southern California ID Associates Inc* to release medical information to the individual/organization as identified above.

Patient/Authorized Signature **Print Name** **Date**