**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**