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 _____ **(month/year)** **to** _____ **(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**