Release of Medical Information

Permission to Receive Records

Please complete the following information:

I, _____, with a date of birth, _____, give my permission for
(PATIENT NAME) **(PATIENT D.O.B.)**

_____ to give my medical records (as described on p. 2) to
(NAME OF INSTITUTION HOLDING RECORDS)

Central Coast Medical Recommendations so that he / she can better understand my condition and help me.

Permission to Receive Sensitive Information

By putting my initials by each item below, I understand that I give permission for records to be sent that may contain information about:

Mental Health _____
Transmittable Diseases Such as HIV/AIDS _____
Genetic Records _____
Drugs and Alcohol Records _____

I Understand That:

- I do not have to give my permission to share these medical records.
- If I want to revoke permission for my doctor to receive these medical records, I must discuss this with a staff member or my doctor and sign a form explaining this.
- This form is only effective for three months from the date I sign it.

Patient's Signature _____ **Date** _____

Authorized Representative's Signature _____ **Date** _____

Relationship of Authorized Representative to Patient _____

Release of Medical Information

Consent for release of medical records for _____
(PATIENT NAME)

Date: _____

Requesting records from:

Name of Practice:_____

Name of Physician:_____

Fax number:_____

Address:_____

_____

Types of Records Requested

☐ Any and all types of records you have for this patient

☐ Doctor visit notes
☐ Emergency Room notes
☐ Urgent care notes
☐ History and physical
☐ Hospital Progress Notes
☐ Operation or procedure notes
☐ Clinic notes
☐ Pathology reports
☐ Doctors orders
☐ Nurses notes
☐ Discharge Summary
☐ Lab reports
☐ Radiology Reports
☐ Consultations
☐ Other _____

Records within the following dates:

☐ All records for this patient

☐ Records dated between _____and _____

Please Send Records to:

Attention: Central Coast Medical Recommendations

At fax number: (805) 481-1181

Or mail to: Central Coast Medical Recommendations

405 East Branch St., Suite 100

Arroyo Grande, CA 93420

For any questions please call: (805) 481-1181