San Diego Surgical Specialists
7910 Frost Street, Suite 250, San Diego, CA 92123
Phone: (858) 565-0104 Fax: (858) 565-0194

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information and instructions before completing and signing the authorization form.

Patient's Name_____**Birth Date**_____/_____/_____
(Please print) **Last** **First** **MI** **Month/Date/Year**

Are medical records filed under another name? YES NO If yes, please provide the name(s):_____

INFORMATION TO BE RELEASED BY:
REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER

_____
Organization/Person Name

_____
Street Address

_____
City State Zip Code

_____
Phone Number Fax Number

INFORMATION TO BE RELEASED TO:

San Diego Surgical Specialist
7910 Frost Street, Suite 250
San Diego, CA 92123
PH#: (858)565-0104
Fax#: (858)565-0194

TYPE OF MEDICAL INFORMATION REQUESTED (Place an X below)

___Complete medical record abstract (includes 3 years of chart notes, most recent labs/pathology & diagnosis imaging reports
___Cancer Partnership records ___Radiology/Diagnostic Imaging (CD/Films) ___Mammogram Diagnostic Imagaing (CD/Films)
___Electrocardiograms ___Pharmacy ___Behavioral Health records only
___My health information relating only to the following treatment or condition: _____
___My health information only for the following dates: _____
___Other_____

REASON FOR REQUEST:
___Personal ___Transfer of care ___Disability ___Insurance ___Legal Review ___Other (please explain)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing, or treatment, unless you specifically exclude below.

_____

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicated that I hereby agree to and authorize the release of patient health information to the above named organization. You have the authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

This authorization expires on_____(date or event). Authorization will expire in 90 days if not otherwise specified.

Patient signature_____Date_____

Parent or Legal Guardian_____Date_____

Relationship to parent, if other than patient_____
(You may be required to provide legal documentation as proof of attorney or guardianship)