

## General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name	
Address	
City, State Zip	
Phone	
SSN	
Date of Birth	

I authorize the custodian of records of: BERKELEY PRIMARY CARE to disclose/release the following information.

All Medical Records

Please send the records listed above to

Temescal Creek Medicine  
405 49<sup>th</sup> Street  
Oakland, CA 94609  
voice 510 230 2372  
fax 877 512-3804

The information may be used/disclosed for each of the following purposes:

- At my request (only the patient can check this box)
- For my health care
- For payment/insurance
- For employment purposes
- Other:

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information. Please be aware during the short time your physical chart is with Dr. Franchett, BPCMC may have limited access.

\_\_\_\_\_  
Signature of patient (or patient's personal representative)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Printed name of patient representative Representative's authority to sign for patient, (*i.e parent, guardian, power of attorney for healthcare, executor*)

**PLEASE FAX COMPLETED FORM BACK TO 1 877 512 3804**