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:

Doctors Name_____
Address_____
Phone _____Fax_____

to disclose/release the following information.

- ☑ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Billing records
- ☐ Abstract/Summary
- ☐ Pharmacy/prescription records
- ☐ Other (describe specifically)

Please send the records listed above to

Temescal Creek Medicine
405 49th 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.

_____ _____ _____
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