Release of patient information from /HIPPA Compliant Authorization

Information obtained from:

Name of Healthcare Provider/Physician/Facility

Street Address

City, State and Zip Code

Patient:_____

Date of Birth:_____**Social Security**:_____

I authorize and request the disclosure of all protected health information for the purpose of review, evaluation and treatment. I understand the disclosure of my medical record may contain information regarding sexually transmitted diseases, and/or drug and alvohol use. I expressly request that the designated record custodian of all covered entities under HIPPA identified above disclose full and complete protected medical information including the following:

Initial_____All medical records, meaning every page in my record, including: office notes, face sheets, history and physical examinations, consultation notes inpatient, outpatient, and emergency room treatment, laboratory reports, progress, nurse's notes, social worker records, treatment plans, admission records, correspondence's, test results. Photographs, Videotapes, and records received by other medical providers. **Please mail records greater than 50 pages to:**

EXCELLENCE MEDICAL GROUP, INC
755 N IRWIN STREET
HANFORD CA 93230
559-585-1200
844-570-7675 FAX

Any facsimile, copy or photocopy of the authorizations shall authorize the release of medical records requested herein.

Signature of patient or legal, authorized representative **Date**

Staff Signature **Date**