



Health Center

MEDICAL INFORMATION REQUEST/RELEASE

AUTHORIZATION TO RECEIVE MEDICAL INFORMATION

Patient Name:		Date of Birth:
Social Security Number:	Date(s) of Treatment Requested:	Type of Information Requested:

AUTHORIZATION

**NAME OF HOSPITAL OR PHYSICIAN RECORDS
ARE TO BE SENT FROM:**

Name of Organization: _____

Address: _____

City/State/Zip: _____ Phone: (____) _____

RECORDS TO BE SENT TO:

**Westside Family Health Center
1711 Ocean Park Boulevard
Santa Monica, CA 90405
(310) 450-2191 Tel (310) 450-0873 Fax**

RESTRICTIONS

I hereby consent to the release of any and all records containing:

- Alcohol and/or Drug Abuse
- Psychiatric Diagnoses
- Results of HIV tests performed
- All other medical information

(I understand that such information cannot be released without my specific consent, except in accordance with a court order.)

I understand that the recipient may not further disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

**DURATION
OF CONSENT**

I hereby give my permission for a copy of my medical records, which are held at the above location, to be released to the Westside Family Health Center. This consent shall become effective immediately and shall remain in effect for six months.

Date: _____ Patient Signature: _____

Date: _____ If signed by other than patient,
Indicate relationship: _____

Date: _____ Witness: _____



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RESTRICTIONS

I hereby consent to the release of any and all records containing:

- | | |
|---|--|
| <input type="checkbox"/> Alcohol and/or Drug Abuse | <input type="checkbox"/> Psychiatric Diagnoses |
| <input type="checkbox"/> Results of HIV tests performed | <input type="checkbox"/> All other medical information |

(I understand that such information cannot be released without my specific consent, except in accordance with a court order.)

I understand that the recipient may not further disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

DURATION OF CONSENT

I hereby give my permission for a copy of my medical records, which are held at the above location, to be released from Westside Family Health Center. This consent shall become effective immediately and shall remain in effect for six months.

Date: _____ Patient Signature: _____
 Date: _____ If signed by other than patient,
 Indicate relationship: _____
 Date: _____ Witness: _____