COMMUNITY MEDICAL PROVIDERS
Medical Group
Caring for you and your family

FOR AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
MEDICAL RECORDS RELEASE REQUEST

HIPAA RELEASE FORM

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

SECTION I

I,_____ give my permission for _____to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

SECTION II – HEALTH INFORMATION

I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

OR

☐ Disclose my complete health record except for the following information:

☐ Mental health records

☐ Communicable diseases including, but not limited to, HIV and AIDS

☐ Alcohol/drug abuse treatment records

☐ Genetic information

☒ Other (Specify) PROBLEM LIST, SHOT RECORD, GROWTH CHART & ANY RECORDS DEEMABLY NECESSARY FOR THEIR CARE

Form of Disclosure:

☒ Electronic copy or access via a web-based portal

☒ Hard copy

SECTION III – REASON FOR DISCLOSURE

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

TRANSFERRING CARE / NEW PCP

COMMUNITY MEDICAL PROVIDERS
Medical Group
Caring for you and your family

FOR AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
MEDICAL RECORDS RELEASE REQUEST

SECTION IV – WHO CAN RECEIVE MY HEALTH INFORMATION

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

NAME: MEDICAL RECORDS DEPT

ORGANIZATION: NORTHWEST PEDIATRIC MEDICAL GROUP

ADDRESS: 7355 N PALM AVE, FRESNO, CA 93711

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

SECTION V – DURATION OF AUTHORIZATION

This authorization to share my health information is valid:

☐ From _____ to _____.

☒ All past, present, and future periods

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

NAME: _____

ORGANIZATION: _____

ADDRESS: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

COMMUNITY MEDICAL PROVIDERS
Medical Group
Caring for you and your family

FOR AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
MEDICAL RECORDS RELEASE REQUEST

SECTION VI – SIGNATURE & IDENTIFICATION

Signature: _____ Date: _____

Print your name: _____

Date of birth: _____ Phone Number: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

_____

_____

_____