AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below. **Failure to provide all information requested may invalidate this Authorization.**

I hereby authorize _____/_____to disclose a copy of the
Name of Releasing Party or Facility ***Phone***
specific health information identified below for:

_____ _____ (____)_____
Patient Name ***Date of Birth*** ***Telephone***

To **Fresno Children's Medical Group**; ***P: (559) 438-2300/ F: (559) 438-1531/ADDRESS: 7720 N. Fresno St. Suite 104 Fresno, CA 93720***

The request is made for the following purposes: *(Please check all which apply)*

_____ Transfer of care _____Personal Use _____To obtain additional benefits _____Attorney Use _____Payment of a claim

Other: _____

I specifically authorize the use and/or disclosure of the following health information to the extent such information and/or medical records exist. Please specify what health information you would like to request.

Type of Information	[X] which apply	Dates Associated with the Information (or list "All")
All Records		
Visit History		
Immunization Records		
Laboratory Reports		
Radiology Reports		
Diagnostic Reports		
Billing Records		
Other:		

I understand that treatment, payment, enrollment or eligibility for benefits will not be denied based solely on my refusal to provide this authorization, unless the following applies:

i. the treatment is research-related and the recipient identified above is seeking to use the information to conduct such research;
ii. the recipient is a health plan which seeks to obtain information (except psychotherapy notes) in connection with my eligibility or future enrollment in the health plan; or
iii. the sole purpose of the treatment is to create health information to provide to the recipient identified above.

I understand:

- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **7720 N. Fresno St. Suite 104 Fresno, CA 93720**
- There may be exceptions where the revocation of the authorization may not be able to be honored.
- There is a potential for the information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected.
- Any valid written revocation received by Fresno Children's Medical Group shall not apply to information that has already been released pursuant to this authorization or affect actions taken by Fresno Children's Medical Group prior to such written revocation. This authorization will expire on date: _____ or one year after this dated form. I may request a copy of this form.

Signature: _____Date:_____Time:_____

Please state your legal relationship to the patient: _____

Witness Name and Signature: _____