Pacific Family Practice Medical Group

A PROFESSIONAL COROPORTATION

I Authorize: To Disclose To:

Name of Disclosing Party			Name of Recipient		
Address			Address		
City	State	ZIP	City	State	ZIP

Records and Information Pertaining To: (Please PRINT clearly)

Patient's Name: _____
Last First Middle

Patient's Birth Date: _____/_____/_____
(MM/DD/YYYY)

Patient's Address: _____
Street City State/ ZIP

Duration: This records release will remain in effect for one year (12 months) unless otherwise specified here: _____ date(s)

Revocation: This authorization is also subject to written revocation by the patient at any time. This written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

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

Specify Records: Check the box [X] to specify which type of information is to be disclosed, then sign and date at the bottom.

☐ Medical Information/ Records

☐ Psychiatric Information/ Records

☐ Other Health Information: _____
(Specify Records to Disclose)

A copy of this authorization is valid as the original. Patient has a right to a copy of this authorization.

_____ _____ _____
Date Signature If Signed by Other than Patient, Indicate Relationship