

Patient Name: _____
 Date of Birth: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____
 Email (recommended): _____
 Medical Record #: _____



**AUTHORIZATION FOR RELEASE
 OF HEALTH INFORMATION**

Verbal Communication
 'Copies' of Medical Records

I hereby authorize:	To release health information to:
Name of person / facility to release health information	Name of person / facility to receive health information
Street Address, City, State, Zip Code	Street Address, City, State, Zip Code

Type(s) of health information to be released for the following date range: _____ to _____

Medical Records Radiology Images Report Billing Records Other: _____

Records limited to the following providers(s) or department(s): _____

I further authorize the release of information for treatment provided after the date of signature on this authorization, as long as such treatment occurs while this authorization has not expired. _____ (initials)

The information below is protected by law and will not be released unless you specifically authorize:	
Mental Health (<i>Other than psychotherapy notes</i>) <i>For psychotherapy notes, complete the psychotherapy authorization form.</i>	Drug/Alcohol Abuse Treatment Records
Communicable Disease Records (<i>Including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis</i>).	Genetic Testing Information Records
	HIV Records

Delivery Option (Select one if you are requesting a Release of 'Copies' of Medical Records):			
Electronically	US Mail	Fax	On-Site
MyChart (<i>no fee</i>) Secured Email: (<i>email address required</i>) _____@_____	Paper	Fax (<i>continuation of care only</i>) Fax # _____ - _____ - _____	In Person Digital Review

Verbal Release (Select approved communication method(s)):		
In Person	By Phone (<i>phone number required</i>) _____ - _____ - _____	May Leave Detailed Voice Messages

Verbal Communication: WellSpace Health has my permission to discuss the above-selected information with the individual identified for the purposes of allowing such individual to be involved in my care and/or for communicating the status of my condition and treatment. _____ (initials)

Copies of Medical Records: WellSpace Health has my permission to release copies of my medical records to the individual or entity identified above. _____ (initials)

Notice: I understand that I do not have to sign this form, and that I should only sign it to permit WellSpace Health to share the information identified above with someone involved in my care. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. _____ (initials)

Your Rights: This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon signing this form. You may revoke this authorization at any time. The revocation must be in writing, signed by you or your patient representative, and mailed to WellSpace Health Records, 1500 Expo Parkway, Sacramento, CA 95817. The revocation will take effect when WellSpace Health receives and processes the request. A copy of this authorization is valid as the original. You are entitled to receive a copy of this authorization. _____ (initials)

Expiration of Authorization: Unless otherwise revoked, this authorization expires _____ (insert date). If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

Date	Print Name	Patient/Patient Representative Signature	Relationship
Interpreter Signature, if applicable			