Authorization to Release
Protected Health Information

Name of Patient: _____

Street Address: _____**City:** _____**State:** _____**Zip:**_____

Telephone Number: _____ **Date of Birth:** _____ **SS#:**_____-___-_____

Release From: _____
(Please list name of sending physician or facility)

Release to:

CompCare Medical Group, Inc.
15944 Los Serranos Country Club Drive
Suite 110
Chino Hills, CA 91709 **Fax Number: (909) 597-8681 (Please fax, whenever possible)**

Reason for Release: (please check)

- ____ Transfer of Medical Care
- ____ Claim for reimbursement
- ____ Legal
- ____ Other:_____

Specified information to be released:

Dates of Treatment: _____
(If "ALL", please indicate)

Type of Treatment: (if specific date is listed above, check all that apply)

☐ **Health Summary** ☐ **Inpatient** ☐ **Emergency Room** ☐ **Specialty Consults**

☐ **Immunization Records** ☐ **Operative Reports** ☐ **Laboratory Reports** ☐ **Progress Notes**

☐ **Discharge Summary** ☐ **Pathology Reports** ☐ **X-ray Reports** ☐ **Other**

Other (specify):_____

I understand that the information disclosed may contain testing or treatment information relating to Mental Health; Drug and/or Alcohol Abuse Treatment; Sexually Transmitted Diseases; HIV/AIDS virus.

I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulation.

I understand that this form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing, Attn: Privacy Officer.

I understand that refusal to sign this authorization does not condition treatment.

Signature of Patient: _____ **Date:** _____

Signature of Other Authorized Person: _____**Date;**_____

Relationship to Patient or Authority to Act for Patient: _____

Signature of Witness: _____ **Date:** _____