FRESNO
HOLISTIC MEDICINE
A NATUROPATHIC WELLNESS CENTER

Authorization to Release or Request Confidential Medical Records

I hereby authorize:

Facility name ____

Phone ______________________ Fax ______________________

Address ____

City/state/ zip ____

To release information from the health records of:

Name ____

Date of birth ______/______/______ Phone: ____________________

Treatment: From ______________________ to ________________________

Information to be released:

_______Lab Results ______________________________________

_______Diagnostic Radiology Reports ____________________________

_______Complete health records_______________________________

_______Other (specify) ______________________________________

Information is to be released to:

Facility name **Fresno Holistic Medicine**
Address **6225 N. Fresno St #103**
City/state/zip **Fresno, CA 93710**
Phone/Fax: 559-470-3435/ 559-475-6590

Purpose of disclosure: ______ ***Cooperative Care*** ______________________

This authorization is valid for ninety (90) days from the date signed. I understand that this consent can be revoked by me at any time, unless disclosure has already occurred in compliance with this consent.

Unless specifically excluded, this authorization includes release of *specially protected records* requiring specific written consent. This includes referral to, diagnosis of and treatment for substance abuse, mental health conditions and sexually transmitted diseases including HIV (CFR 42, part 2). Certain records also require a minor's consent. This applies to persons aged 13 to 18 for records pertaining to substance abuse and mental health records, or persons aged 14 to18 for records pertaining to sexually transmitted diseases and HIV/AIDS.

I understand that I do not have to sign this authorization in order to get health care benefit (treatment, payment, enrollment, or eligibility for benefits) except if I receive healthcare when the sole purpose of the healthcare is to create health information for a third party.

I understand that: a) I must revoke my authorization in writing and may do so by completing and signing the Revocation of Authorization from, available at my clinic's business or medical records office; b) If I revoke my authorization, it will not affect any actions already taken by Fresno Holistic Medicine based upon this authorization; and c) I may not be able to revoke this authorization if the purpose if the purpose of it was to obtain insurance.

Fresno Holistic Medicine has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information. I understand that this authorization does not permit the release of information related to health care provided to me more than ninety days after the date of this authorization. This prohibition dose not extend to insurance companies

Patient/guardian signature ________________________________ Date: ____________

Minor/witness signature ________________________ Relationship to patient __________________

Revised 4/19/2017