Rocklin Family Practice & Sports Medicine
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AUTHORIZATION FOR USE / DISCLOSURE OF HEALTH INFORMATION

This authorization allows Rocklin Family Practice & Sports Medicine and its physicians to release confidential medical information and records on my behalf. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

To release information regarding my: (initial the following)

_____ Appointment dates & times
_____ Reason for appointments
_____ Medical history
_____ Illness or injury
_____ Consultation
_____ Prescriptions
_____ Treatment (including coverage and benefits)
_____ Diagnosis or prognosis
_____ Test results (lab, pathology, radiology, etc.)
_____ Correspondence
_____ All billing information
_____ Referrals and authorizations
_____ Durable Medical Equipment
_____ ALL OF THE ABOVE

TO: _____ Relation to patient: _____

TO: _____ Relation to patient: _____

TO: _____ Relation to patient: _____

TO: _____ Relation to patient: _____

I do consent to the specific release of the following records. I understand that the following information cannot be released without my specific consent.

Drug/alcohol/substance Abuse _____ (initial)
Psychiatric/Mental Health _____ (initial)
Test for antibodies to HIV _____ (initial)
HIV Diagnosis/Treatment _____ (initial)
Genetic Information _____ (initial)

DURATION: This authorization shall be effective from the following dates: _____ to _____

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____
Signature of patient *or legal guardian*

_____
Relationship *if other than patient*

_____
Patient's Name (**Print please**)

_____
Date

_____
Patient's Date of Birth