

**Rocklin Family Practice and Sport Medicine**  
**3104 Sunset Blvd. 2b Rocklin, Ca 95677**

**Phone number 916-624-0300 Fax 916-624-0631**  
**Roy Harris MD - Kuo Ooi MD - Biljinder Chima MD**  
**Sharndeeep Bains DO**

**Medical Records Release Form**

This authorization allows healthcare provider(s) named below to release confidential medical information and record. Note: information and records regarding treatment of minors HIV, psychiatric/mental health conditions or alcohol/substance abuse have special rules that require specific authorization.

Print name of Patient \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_

**My Authorization**

I here by authorize \_\_\_\_\_

Physician/Healthcare Facility

Phone Number

\_\_\_\_\_  
Address City State Zip Code

**To use or disclose the following health information**

All of my health information (unlimited)

My health information relating to the following treatment or condition (limited)

\_\_\_\_\_

My health information covering the period from \_\_\_\_/\_\_\_\_ (Date) to \_\_\_\_/\_\_\_\_ (Date)

**I also consent to the specific release of the following records (initial for consent)**

Drug/alcohol/substance abuse \_\_\_\_\_ Psychiatric/mental health \_\_\_\_\_

Test for antibodies to HIV \_\_\_\_\_ HIV diagnosis /Treatment \_\_\_\_\_

Genetic information \_\_\_\_\_

**The above party may disclose this health information to the following recipient:**

Name or title of organization \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_ Fax number \_\_\_\_\_

This authorization ends (date) \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_