

Rocklin Family Practice and Sport Medicine  
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### 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 \_\_\_\_\_

Email \_\_\_\_\_

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

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

Signature \_\_\_\_\_

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