General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name	
Address	
City, State Zip	
Phone	
SSN	
Date of Birth	

I authorize the custodian of records of:

Doctors Name____

Address____

Phone _________________________Fax_________________________

to disclose/release the following information.

□ All records □ As Specified:

Please send the records listed above to

Temescal Creek Medicine
405 49th Street
Oakland, CA 94609
voice 510 230 2372
fax 877 512-3804

The information may be used/disclosed for each of the following purposes:

□ At my request (only the patient can check this box)
□ For my health care
□ For payment/insurance
□ For employment purposes
□ Other:

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information.

___________________________________ _____ ___________________________

Signature of patient (or patient's personal representative) DATE

___________________________________ _

Printed name of patient representative Representative's authority to sign for patient, *(i.e parent, guardian, power of attorney for healthcare, executor)*

PLEASE FAX COMPLETED FORM BACK TO 1 877 512-3804