



Ventura Pulmonary and Critical Care Medical Group

AUTHORIZATION FOR RELEASE OF INFORMATION FAMILY/FRIEND

I, _____

(FILL PRINTED NAME AND CHECK ONE BOX BELOW)

Direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

DECLINE *(SIGN AND DATE BELOW)*

(Required) Name:

(Required) Phone#

Health information to be disclosed upon the request of the person named above **(Circle either A or B):**

- A.** Disclose my complete health record (including or not limited to diagnoses, lab test, prognosis, treatment, and billing for all conditions) **OR**
- B. Disclose** my health record, as above **BUT do not disclose the following** *(Check as appropriate):*
 - Mental health records
 - Communicable diseases (including HIV and AIDS)
 - Alcohol/drug abuse treatment
 - Other (please specify): _____

Form of disclosure (unless another format is mutually agreed upon between my provider and designee):

- An electronic record
- Hard copy

This authorization shall be effective until **(Check one):**

- All past, present, and future periods, **OR**
- Date or event: _____

Unless I revoke it (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

We will charge 0.25 per page for copies of your records. There are no fees to release records to another doctor or medical facility via fax.

Printed name of the individual giving this authorization

Signature of the individual giving this authorization

Date