91 Gregory Lane, Suite 13, Pleasant Hill, CA 94523
hello@calmedciti.com | (925)665-0008 | www.calmedciti.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I **request and authorize** _____

to release healthcare information of the patient named above to:

Name: **Selfcare by CalMedCiti**

Address: **91 Gregory Lane, Suite 13, Pleasant Hill, CA 94523**

Phone: **925-665-0008** Fax: **925-956-7181**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

I understand that my records are protected under Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable Includes: Diagnosis, Procedure, and Treatment for Physical or Psychiatric Illness, or treatment for Alcohol or Substance Abuse or HIV Testing for any admission.

I understand that my physician's office and staff will rely on my consent on this form until I cancel it. A photocopy of this authorization shall be as valid as the original.

The patient's medical record is privileged information, which is protected by various State and Federal laws. Such information may not be further disclosed to other persons or entities without a separate written authorization from the patients.

Patients must sign unless he/she is a minor or is unable to sign. If signature is not the patient, indicate legal relationship to patient.

Patient Name (PLEASE PRINT): _____

Patient Signature: _____ **Date Signed:** _____

Relationship to patient if not signed by patient: _____