Sacramento Naturopathic Medical Center

Authorization for the Release of Medical Records

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursement for records received.

Patient: _____ DOB:_____/_____/_____

Please obtain information from the following:

Name of Physician _____ Phone _____

Name of Clinic/Hospital _____ Fax _____

Street Address_____ City / State / Zip _____

Please send my medical information to:

Sacramento Naturopathic Medical Center • 2530 J Street, Suite 100, Sacramento, CA 95816
or fax to 916-446-2592 • phone 916-446-2591

By checking the boxes below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation, fax, or electronically:

❑ Laboratory reports ❑ Diagnostic imaging reports ❑ Medical records needed for Continuity of care

Expiration: This authorization will automatically **expire one (1) year** from the date of execution unless a different end date is specified. **DIFFERENT END DATE** _____

_____ _____

Patient Signature Date Signature of Parent/Guardian if Applicable Date

I understand that certain information in these records cannot be released without **specific authorization** because of federal or state laws. Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R Part 2. **By signing** the spaces below, **I specifically authorize the release of the following confidential information.** I understand that I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation, fax or electronically.

_____
Patient Signature

HIV/AIDS test results and related information, including high risk behavior documentation. This information may not be further disclosed without the specific written authorization of the tested individual.

_____
Patient Signature

Drug/alcohol diagnosis, treatment, or referral information. Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Please provide a description of this information.

_____

_____
Patient Signature

Mental health treatment information.