CUCAMONGA VALLEY™
MEDICAL GROUP

Authorization to Release or Receive Medical Records

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Privacy Act:

PATIENT'S FIRST AND LAST NAME _____ SOCIAL SECURITY NUMBER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ CELL _____ BIRTHDATE _____

I hereby authorize (those named below):

NAME OF PHYSICIAN / PROVIDER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

to furnish to (those named below):

NAME OF PHYSICIAN / PROVIDER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

Purpose for Disclosure: ☐ Continuing Care ☐ Insurance ☐ Legal Purposes ☐ Personal Use

☐ Other / Specify: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of the following information from service dates _____ to _____

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. Unless otherwise revoked, this authorization will expire one year from the date of signature. I understand that signing this form is voluntary, and that I may revoke this authorization at any time in writing, which must be mailed to ***16465 Sierra Lakes Parkway, Suite 300, Fontana, CA 92336***. I understand that I have the right to inspect and/or obtain a copy of the material to be disclosed. Cucamonga Valley Medical Group will not re-disclose this information, except with a written authorization or as specifically required or permitted by law. Cucamonga Valley Medical Group will not condition the provision of care or the receipt of benefits on signing this authorization. A copy of this authorization shall be as effective as the original and I have the right to receive a copy of this authorization. I release, hold harmless and agree to indemnify this Healthcare Facility, it's employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

I specifically authorize this Healthcare Facility to use and disclose verbally, by mail, fax, encrypted or unencrypted email, the following types of super-confidential information as stated in the NOPP. *Initial where appropriate:*

_____ INITIALS Alcohol and substance abuse diagnosis and treatment records

_____ INITIALS HIV records (including HIV test results) and sexually transmissible diseases

_____ INITIALS Mental Health Records

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE (IF APPLICABLE) _____ DATE _____

PRINT NAME OF PATIENT'S LEGAL REPRESENTATIVE (IF APPLICABLE) _____ RELATIONSHIP TO PATIENT _____