AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Total # of pages:_____ Date:___/___/____ Attn:_____

I, **the person signing below**, request the following information:

☐ X-rays (actual films or CD) ☐[_____Lab/Imaging]Report (over the last year)
☐ Diagnosis ☐ Recent Treatment Other _____

To be released to: Jay T. Hobbs, D.C. at the address or fax listed below,

For the purpose of: ___Evaluation_____

According to Section 123.110 of The California Health & Safety Code, these records/films must be transmitted within 15 dates from receipt of this notice.

Effective dates for this authorization: ____/____/____ through ____/____/____. This authorization will expire at the end of the above period. If no dates are indicated this authorization will remain valid for 30 days.

Patient initial if authorizing: Records may be released by: _____fax, _____email

Patient Name:_____ Date of Birth: ___/____/___

Signed: _____ Today's Date: : ___/____/___

☐ Parent / Guardian (print name of guardian or Parent here _____

Patient Rights:

1. You may revoke this authorization at any time during the effective dates by sending written notice.
2. You may refuse to sign this authorization without negative consequences to treatment.
3. You may receive a copy of this authorization.
4. You may restrict what is disclosed by this authorization.

Office Use Only:
date received _____/_____/_____
and type: ___ [ ] disc, ___ [ ] paper, ___ [ ] Fax ___, [ ] Film___

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