Friends of Family Health Center

501 S. Idaho St.
La Habra, California 90631
Phone: 562-690-0400 Fax: 562-690-3182

AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL INFORMATION

Confidentiality of medical Information Act of 1980, Section 56 et seq. of the California Civil Code. California Welfare and Institution Code Section 5328, Federal Alcohol and Drug regulations.
This authorization to receive or release the below indicated information is being requested of you to comply with the terms of the corresponding civil code and/or regulation(s).

Patient Name: (or other names used, maiden or alias)	Date of Birth	Social Security Number
Patient Address:	City, State, Zip Code	Telephone Number
Member/Medical Record Number	Group/Patient Number	Spouse's Name

I HEREBY AUTHORIZE (THOSE NAMED BELOW):	**PROVIDE TO (THOSE NAMED BELOW):**
Name of Provider/Practitioner	Name of Recipient
Name of Medical Facility	Name of Medical Facility
Address	Address
City, State, Zip Code	City, State, Zip Code
Telephone and Fax Number	Telephone and Fax Number

COPY/RELEASE THE FOLLOWING INFORMATION FROM MY RECORDS (CHECK ALL THAT APPLY):

☐ History and physical examination _____	☐ Operative Reports _____	☐ Laboratory _____
☐ X-ray Films _____	☐ Pathology Reports _____	☐ X-Ray reports _____
☐ ER/Urgent Care _____	☐ Consultation _____	☐ Progress/Doctors Notes _____
☐ Immunizations _____	☐ Hospital Records _____	☐ Pathology Slides _____
☐ Alcohol & Drug Abuse Records _____	☐ Discharge Summaries _____	☐ Other _____
☐ HIV _____	☐ Entire file _____	

THE USE OF MY RECORDS IS LIMITED TO THE FOLLOWING (CHECK ONE):

☐ Self	☐ Continuing HealthCare	☐ Worker's Compensation
☐ Other insurance claim _____	☐ Other: _____	☐ Limits: _____

AUTHORIZATION SHALL BECOME EFFECTIVE IMMEDIATELY AND SHALL REMAIN IN EFFECT FOR:

- The above named patient
- The legal representative of the above-named minor patient
- The legal representative of the above-named incompetent patient (must provide legal documentation)
- The beneficiary of personal representative of the above-named patient who is deceased (must provide legal documentation)

I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received ☐ Yes ☐ No
*** Special authorization required to release this information.**
I have been made aware that fees for processing this authorization may apply. I also acknowledge that said fees might be my responsibility.
Patient Initials _____

_____ _____ _____
Date Signature Witness

_____ _____
PRINT Name Address (if other than patient) City/State/Zip Code