



FAMILY PHYSICIANS, INC.

A MEDICAL CORPORATION

J. DAVID MILLER, III, D.O. DWAIN W. RICKERTSEN, M.D. KIMDARY CHEK, M.D. JOHN G. MCAVOY, P.A.

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

MEDICAL RECORDS IN THE POSSESSION OF:

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TO BE RELEASED TO:

FAMILY PHYSICIANS INC.
1233 PLUMAS STREET, SUITE A
YUBA CITY, CA 95991

Patient's Name: _____

Date of Birth: _____

Indicate choices by initialing the blanks

I authorize the release of my complete medical records _____ to the physician and/or facility named above. This includes any and all information related to the examination, diagnosis and treatment rendered to me. I acknowledge that the information may include material related to drug and/or alcohol use _____, mental health conditions _____, and that this information is protected by Federal Law.

Signature: _____
(Parent Signature if patient is a minor)

Date: _____

Witness: _____

Date: _____

Specific Authorization: I acknowledge that information being released may include material related to the diagnosis and/or treatment of HIV (AIDS VIRUS) and that this information is protected by Federal Law. My signature below authorizes the release of this information.

Signature: _____
(Parent Signature if patient is a minor)

Date: _____

Unless revoked, this authorization shall terminate one year from the date signed. You have the right to revoke this authorization in writing. Requests to revoke must be made in writing at our office.

- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.
- Refusing to sign this authorization will not affect a persons(s) right to receive treatment. However, outside agencies which require protected health information to provide various services may not be able to do so.
- Disclosures resulting from this authorization may be in written, electronic and/or verbal form.
- I have a right to receive a copy of this authorization.
- A copy of this authorization is just as valid as an original.

Transferring Out Evaluation Case Planning Other _____

Records for Patient:

- DIGITAL CD: **\$15 processing fee for records being released to the patient**
- PAPER RECORDS: **\$15 plus .25cents per page for records being released to the patient**