MEDICAL RECORDS REQUEST

I hereby authorize the use and disclosure of protected health information from my primary care physician, **David Bruce Christian, MD** at 500 Old River Road, Ste 145, Bakersfield, CA 93311-9509, (661) 664-0434 PH, (661) 664-0432 Fax, **to be furnished to:**

_____

_____ Ph: ( )

_____ Fax: ( )

Information requested for the purpose of: *Changing Primary Care Provider*

Records Copy Fee is $30

- ❑ I will pick up my records.
- ❑ Please mail my records directly to the new provider.

Please circle the number of years you are requesting: 1 2 3 4 5 6 7 8 9 10

Please specify the types of records you are requesting:

- ❑ Progress Notes (Office Visit Notes)
- ❑ Laboratory, Pathology Reports
- ❑ Radiology/Imaging Reports
- ❑ Consultation/Specialist/Operative Rpts
- ❑ Immunization Records
- ❑ Other _____

Disclosures requiring special consent: My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis or treatment for *(initial applicable headings):*

_____ HIV/AIDS virus
_____ Drug / Alcohol Abuse Treatment
_____ Mental Health / Psychiatric Disorders
_____ Sexually Transmitted Disease

This authorization will expire on: _____.
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected. (Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or the discretionary provisions of California Civil Code #56.10(x) may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.)

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt but will not be effective to the extent that this organization has taken action in reliance upon this information.

Patient Name: _____

Address: _____

City: _____ State:_____ ZIP: _____

Birthdate: ____/____/____ Phone: _____

Maiden/Other Name: _____

_____ _____
Signature of Patient or Responsible Party Date