KAREWELL MD PATIENT CARE

CHABOT FAMILY ASSOCIATES, INC.
19845 LAKE CHABOT ROAD, #205. CASTRO VALLEY, CA, 94546 PH: 510-582-6424
2324 SANTA RITA RD, SUITE 8 PLEASANTON , CA , 94566 FAX: 510-582-6462

RELEASE OF MEDICAL INFORMATION

Patient's Full Name | **Patient's Social Security Number/Medical Record Number**

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

I hereby authorize **Chabot Family Associates, Inc.** to obtain protected health information about me From Facility / Provider listed below.

1. Please obtain information from:

Name of Facility / Provider

Address

City, State Zip Code

2. The specific information that should be disclosed is (please initial the option):

_____: **Entire Medical Record** _____: **Immunization, Test and Diagnostics Record**

_____: Medical Records FROM (date) _____ TO (date) _____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, **DO NOT** DISCLOSE THIS INFORMATION *_____

3. Reason for Release of Information (Please initial One and Provide details)
   a. Patient Request For ____ _____.
   b. Other Reason ___ _____
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying **Chabot Family Associates, Inc.** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. This authorization expires on (Initial One) Date _____ Initial _____ OR 90 Days from Signing: Initial _____
7.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places. *

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**
_____	_____	_____
Signature of Parent / Guardian, Personal Representative OR Beneficiary	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signatory.

Official Use Only

_____	_____	_____
Received	**Processed By**	**Log #**