KAREWELL MD PATIENT CARE

CHABOT FAMILY ASSOCIATES, INC.
19845 LAKE CHABOT ROAD, #205
CASTRO VALLEY, CA, 94546
PH: 510-582-6424 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.** for the disclosure of protected health information about me to Person or described 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 _____

FEES FOR COPIES: We charge administrative fees for release of medical record to be paid to Chabot Family Associates, Inc. within 60 days of us accepting the release of recorded request.
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 #**