ID Southern California ID Associates, Inc.
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Authorization for the Release of Medical Information

Patient Name	Telephone	Date of Birth

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name		Telephone
Address		Fax Number
City	State	Zip Code

The purpose or need for disclosure: _____

Date Range of Information to be Released: _____ (month/year) to _____ (month/year)

Please check specific information to be released:

- ☐ Outpatient Progress Notes
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Lab Results
- ☐ Radiology Reports
- ☐ Other (Please Specify):_____

AUTHORIZATION: Permission is hereby granted to *Southern California ID Associates Inc* to release medical information to the individual/organization as identified above.

Patient/Authorized Signature	Print Name	Date