

**JD** Southern California JD Associates, Inc.

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**Authorization for the Release of Medical Information**

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Patient Name	Telephone	Date of Birth
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Above listed patient authorizes the following healthcare facility to make record disclosure:

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Facility Name	Telephone	
Address	Fax Number	
City	State	Zip Code

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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.

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Patient/Authorized Signature	Print Name	Date
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