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### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Type of access requested:  Paper copy of records  CD Copy  Transfer Request

I request access as the:  Patient  Parent/Guardian  Medical Power of Attorney: (Proof of legal documentation is required)

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ Contact Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Check (If **SEND TO** is same as above) **OR** Please REQUEST medical information be  **SENT TO** or  **FROM**

Name of Person or Entity to Receive Information Name of Medical Office/Provider:

Street Address

City, State and Zip Code

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

California law (AB610) allows the healthcare provider a 15-day turnaround time from the date a request is received in order to process a patient's request for copies of their medical records. AIRE turn-around time is about 10 business days.

All General Medical Information (from \_\_\_\_\_ to \_\_\_\_\_). General medical records may include information of diagnosis and / or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This may include information and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. Information regarding specific injury or treatment (from \_\_\_\_\_ to \_\_\_\_\_)

Other (Specify): \_\_\_\_\_

**Duration:** This authorization will expire 12 months from the date signed. **Right to Copy:** I have a right to receive a copy of the Authorization after I sign it.

**Revocation Process:** I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at AIRE Medical Group

**Re-Disclosure Statement:** I understand that once AIRE Medical Group discloses my health information to the recipient, AIRE Medical Group cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization of Applicable law governing the use and disclosure of my health information.

*I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize AIRE Medical Group to use or disclose my health information in the manner described above.*

Date

Signature of Patient or Representative Indicate Relationship (if not signed by patient)