



19111 Town Center Dr. Apple Valley, CA 92308
Phone: (760) 242-7777 Ext 285 Fax: (888) 633-2996

Consent to Release Medical Records

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

1. I hereby request and authorize Choice Medical Group to:

- Release Information TO Obtain Information FROM

2. Name of Provider/ Facility \_\_\_\_\_
Address \_\_\_\_\_
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

3. The PURPOSE of this release is: (check all that apply)
Moving Insurance Purposes Transferring Care Second Opinion
Personal Review Other (please specify) \_\_\_\_\_

4. The FOLLOWING Protected Health Information (PHI) may be released:
(Please check one)

I consent to the release of all medical records including records, Physician consult notes, x-ray reports and lab tests. (This release excludes any records transferred to Choice Medical Group from previous care providers).

I consent to the release of all medical records with the following treatment or conditions with the exceptions of:
\_\_\_\_\_
\_\_\_\_\_

I consent to the release of all medical records from \_\_\_\_\_ to \_\_\_\_\_.
date date

5. This authorization will automatically expire within one year from the date of signature. I understand that I have the right to revoke this authorization in writing at any time, except where information has already been released in response to this authorization.

NOTICE TO PATIENT: There is a \$15.00 processing fee and \$0.10/page fee for any medical records that are requested for personal reasons. NO charge for records sent to another provider.

Medical Records Department Only
Date Received: \_\_\_\_\_
Date Completed: \_\_\_\_\_
Fee: \_\_\_\_\_ Initials: \_\_\_\_\_

Signature of Patient/Representative/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_