



Consent for Release of Medical Information

I hereby authorize _____, or any of it's employees, staff or agents to use and disclose health information from the medical record(s) of:

Patient Name _____

Address _____

Date of Birth _____
Telephone _____
Number or email address _____

Treatment Dates _____
Release Information to: _____
Address for Delivery: _____
(Street) (City, state, zip)

√ Check all that apply.

I consent to release all of the medical information regarding my treatment or hospitalization:

- _____ General hospital or outpatient or medical office care
- _____ Drug and/or alcohol treatment
- _____ HIV/AIDS (requires additional special consent)
- _____ Emergency Room care
- _____ Psychiatric care

I consent to release:

- _____ Entire medical record
- _____ Pertinent abstract including history & physical, operative reports, consultations, discharge summaries, laboratory, radiology and other significant diagnostic study results

I consent to release confidential medical information for the following purpose:

- _____ Continuing medical treatment
- _____ Insurance (company name)
- _____ Other: (specify reason)

This consent permits _____ to use and disclose my health information to carry out treatment, payment, or health care operations. Additional information regarding the uses and disclosures of health information is described in the Marin IPA's Confidentiality Policy. A patient has the right to review this policy prior to signing this release. A patient has the right to request restrictions on the uses and disclosures of health information for treatment, payment and health care operations purposes. However, the Marin IPA is not required to agree with the patient's request for restrictions. I may revoke this consent to release confidential medical information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of additional statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the Marin IPA, its employees, staff and agents, in connection with the disclosure of information set forth relating to these medical records.

_____ Print Patient's Name

_____ Signature of Patient

_____ Signature of Legally Authorized Person

_____ Today's Date

_____ Date Authorization to Release Expires

Send Completed Form To:

**Prima Medical Group
3 Hamilton Landing, Ste. 160
Novato, Ca 94949
ATTN: Medical Records**