LEGAL BEAGLE
1430 Franklin Street Oakland, CA 94612
Phone (510) 451-5650 - Fax (510) 451-1456

AUTHORIZATION FOR RELEASE AND / OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please **REQUEST** Medical Information **FROM**:

_____
Name of Health Care Provider

_____
Name of Medical Office/Hospital

_____
Street Address

_____
City, State and Zip Code

Please **SEND** Medical Information **TO**:

c/o Legal Beagle
Name of Person or Entity to Receive Information

_____
Title (Physician, Therapist, Attorney)

1430 Franklin St.
Street Address

Oakland, CA 94612
City, State and Zip Code

I hereby authorize _____ to release and / or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Release and / or disclose records and information regarding:

_____ _____ _____
Name of Patient (List Other Names Used) Medical Record Number Date of Birth

_____ ( ) _____
Address City State Zip Code Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until _____(*enter date*) or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS TO BE RELEASED AND / OR DISCLOSED:

Check the box and initial which type of information is to be released and / or disclosed:

- ☐ **General Medical Information** *(from_____ to_____)*
- ☐ **Information Regarding Specific Injury or Treatment** *(from_____ to_____)*
- ☐ **X-Ray (check one or both):** ☐ **Films** ☐ **Reports**
- ☐ **Laboratory Results**
- ☐ **Mental Health** *(from_____ to_____)*
- ☐ **Alcohol / Drug** *(from_____ to_____)*
- ☐ **HIV Test Results** *(from_____ to_____)*
- ☐ **Other (specify):** _____

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Signature of Patient or Patient's Representative Date

I request that the health information released and / or disclosed pursuant to this authorization be used for the following purposes only: _____

A copy of this authorization is valid as an original.
I have the right to receive a copy of this authorization. The copy is for me to keep.

_____ _____ _____
Date Signature of Patient or Patient's Representative Indicate Relationship (if Signed by Other than Patient)

Submit Reset Print This Form