Graybill
Medical Group
www.graybill.org

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Phone: (866) 228-2236
Fax: (760) 738-9047

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

I hereby authorize the disclosing physician or health care provider noted below to release medical information to the receiving physician or health care provider indicated:

FROM: _____ TO: **Graybill Medical Group**
(Name of disclosing physician or provider) *(Name of receiving physician or provider)*

_____ **225 E. Second Ave, Escondido, CA 92025**
(Address) **(City, State, Zip Code)** **(Address)** **(City, State, Zip Code)**

Release records and information regarding: _____
(Patient's Name)

_____ _____ _____
(Date of Birth) **(Social Security #)** **(Telephone Number)**

_____
(Address, City, State, Zip Code)

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

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

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

SPECIFY RECORDS: ☐ **Medical Information** ☐ **X-Ray**

☐ **Psychiatric Information**

_____ _____

Signature ***Date***

☐ **Drug/Alcohol**

_____ _____

Signature ***Date***

☐ **HIV Test Results**

_____ _____

Signature ***Date***

☐ **Other (Specify)** _____

I request that the health information released pursuant to this authorization be used for the following purposes only:

_____

_____

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

*Patient/Guardian Signature:*_____ *Date:*_____

_____

Relationship to patient (if signed by other than patient)

CONFIDENTIAL INFORMATION MAY BE ACCESSED BY BACTES CORPORATION EMPLOYEES FOR PURPOSES OF PHOTO COPYING INFORMATION IN RESPONSE TO PROPERLY AUTHORIZED REQUESTS FOR COPIES OF MEDICAL RECORDS.

YOUR RECORDS FOR 2 YEARS IS ALL THAT WILL BE COPIED UNLESS OTHERWISE REQUESTED. THERE MAY BE A CHARGE FOR RECORDS OLDER THAN 2 YEARS.

THE COPYING PROCESS USUALLY TAKES 15 WORKING DAYS. RECORDS WILL NOT BE FAXED.