Salinas Valley PrimeCare Medical Group, Inc.

355 Abbott Street, Suite 100, Salinas, CA 93901 - Phone 831-751-7070 Fax 831-751-7050

Patient Name: _____ Date of Birth: _____

I authorize and request the disclosure of my protected information. I expressly request that _____ disclose the following:

- ☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical reports, order sheets, progress notes, nurse's notes, treatment plans, admission records, discharge summaries, documents, correspondence, diagnostic and procedure reports, and test results.

- ☐ Other (list dates of service and details of requested information):
  EKG (dates of service) _____
  Lab results (dates of service) _____
  Physician notes (dates of service) _____
  Radiology/Ultrasound (dates of service) _____
  Other (dates of service) _____

You are authorized to release the above records to the following representatives and I agree to pay $0.25 per page plus postage if records are mailed, in accordance with Health & Safety Code Section 123110.

Released to : _____
Address: _____
Phone number: _____ Fax number: _____

I hereby authorize and request that my protected health information be disclosed to the party I have identified above. I have a right to revoke this authorization in writing at any time, except to the extent the information has been released in reliance upon this authorization. The information released in response to this authorization may be re-disclosed to other parties. Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested herein. I understand I have a right to receive a copy of this authorization. This authorization shall be in force and in effect until requested records have been released.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Printed Name of Patient or Legally Authorized Representative Relationship

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For PrimeCare administrative purposes only Date received by PrimeCare: ___ / ___ / ___ Initials: _____

Date patient or requesting office informed of charge: ___ / ___ / ___ Initials: _____

Total charge $ _____ . ___ Date received: ___ / ___ / ___ ☐ Check ☐ Cash ☐ CC

Date copied: ___ / ___ / ___ By Whom?: _____ Office informed records ready for pick up ___ / ___ / ___

Check one: ☐ Delivered ☐ US mail ☐ Picked up ___ / ___ / ___ Signature : _____