Pacific Cancer Care
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Monterey, CA. 93940
Ph: (831)375-4105
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Medical Records Release Form and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

_____

Phone: _____

SSN : _____ **Date of Birth: ____- ____- _____**

I authorize the custodian of medical records of _____
to disclose/release the following information:

(check all applicable):

- ☐ All Records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Billing records
- ☐ Abstract/Summary
- ☐ Pharmacy/prescription records
- ☐ Other(describe specifically)_____

***Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of information.**

These records are for services provided on the following date(s):_____

Please send the records listed above to:

Name: **Pacific Cancer Care**
Address: **5 Harris Ct. Bldg. T Suite 201 ATTN: Karin Med. Records Dept.**
Monterey, CA 93940
Phone: **831-375-4105**
Fax: **831-372-5722**

This authorization shall expire no later than: _____/_____/_____ or upon the following event_____ (whichever is sooner), and may not be valid for greater than one year from the date of signature. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information.

Signature of patient (or patients personal representative) _____ **Date** _____

Printed name of patient representative _____ **Representative's authority to sign for patient**, (i.e. parent guardian, power of attorney for healthcare, executor) _____

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Administrator, 5 Harris Ct. Bldg. T. Suite 201 Monterey, CA. 93940