Pacific Cancer Care
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Monterey, CA. 93940
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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: __ **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