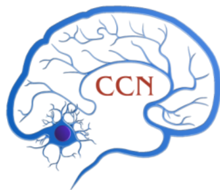

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Release of Information Authorization

This authorization is for the use or disclosure of health information pertaining to:

Patients Name: Last:________________________ First:___________________ MI:____

DOB:____________ Phone Number:____________________ SSN:__________________

Address:____

The following people have my consent to(check all that apply):

- ☐ Have access to all my records
- ☐ Billing Records: *(Request will be forwarded to the Billing Dept for processing) Questions call 916-787-0665*
- ☐ May schedule my appointments
- ☐ May speak to Dr. and/or staff about my records
- ☐ Other Health Information *(Specify):* ____

Name:		
(Last)	(First)	DOB
Name:		
(Last)	(First)	DOB
Name:		
(Last)	(First)	DOB
Name:		
(Last)	(First)	DOB

- I may refuse to sign and my refusal will not affect my ability to obtain treatment.
- The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless the use or disclosure is specifically permitted by law.
- This authorization shall become effective immediately and shall remain in effect until ____________ (If no date is given, authorization is valid for 1 year only from signature date).
- I reserve the right to withdraw or revoke this authorization, in writing, at any time, except to the extent that CCN has already disclosed the information.
- I certify that I have given my consent freely, voluntarily and without coercion and that the information given above is accurate to the best of my knowledge.
- I understand I have the right to receive a copy of this authorization.

Signature:____ Date:_______________

If signed by other than patient, indicate relationship:_______________________________