Central California
Neurology
Medical Corporation

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Records Release Authorization

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

Patients Name: Last:_____ First:_____ MI:____

DOB:_____   Phone Number:_____ SSN:_____

Address:_____

I hereby authorize:

_____   _____
(Name of Person or Organization Releasing Information)   Address   City   St   Zip Code

To disclose health information to:

_____   _____
(Name of Person or Organization Receiving Information)   Address   City   St   Zip Code

This authorization applies to the following information:
☐   Medical Records *(Specify):* _____
☐   Billing Records: *(Request will be forwarded to the Billing Dept for processing)*
☐   Other Health Information *(Specify):* _____

- 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.
- I understand copying my records can take up to 5 business days to process once payment and release is in place.
- I have been notified that the charge for a copy of my records will be **$25.00**

Signature:_____ Date:_____
If signed by other than patient, indicate relationship:_____

Indicate preference: ☐Mail records to the address above ☐Pick-up at CCN ( )Salinas ( )Monterey