# Salinas Family Practice Medical Group, Inc.

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# RELEASE OF MEDICAL RECORDS

**Releasing To:**

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**Releasing From:**

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**Please send the following information, which may include drug or alcohol treatment, mental health, records, and/or HIV information.**

- ❑ All records
- ❑ Lab data
- ❑ Operative reports
- ❑ X ray

**Purpose of Disclosure:**

- ❑ Transfer of care
- ❑ Consult
- ❑ Insurance
- ❑ Other

**You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.**

**Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.**

**Patient has a right to a copy of this authorization.**

**NAME (PRINT)** _____ **DATE OF BIRTH** _____

**SIGNATURE** _____ **DATE** _____

**WITNESS** _____ **DATE** _____