



**AUTHORIZATION TO RELEASE  
MEDICAL RECORDS**

**Phone: (916) 966-8158**

**Fax: (916) 966-8118**

www.vistamedcare.com

Patient Name

Patient Date of Birth

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I hereby authorize the disclosing physician or health care provider noted below to release medical information to the receiving physician or health care provider indicated:

**FROM:**

\_\_\_\_\_  
*(Disclosing physician or provider)*

\_\_\_\_\_  
*(Street Address)*

\_\_\_\_\_  
*(City, State, Zip Code)*

**TO:**

**Vista Medical Associates**

\_\_\_\_\_  
*(Receiving physician or provider)*

**4944 Sunrise Blvd. Suite H**

\_\_\_\_\_  
*(Street Address)*

**Fair Oaks, CA 95628**

\_\_\_\_\_  
*(City, State, Zip Code)*

Release records and information regarding:

\_\_\_\_\_  
*(Patient's Name)*

\_\_\_\_\_  
*(Date of Birth)*

\_\_\_\_\_  
*(Social Security #)*

\_\_\_\_\_  
*(Telephone Number)*

\_\_\_\_\_  
*(Address, City, State, Zip Code)*

**DURATION:** This Authorization shall become effective immediately and shall remain in effect through \_\_\_\_\_ (enter date) or for one year from the date of signature if no date entered.

**REVOCAION:** This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

**REDISCLASURE:** I understand that the requestor may not lawfully further use or disclose the health information unless another Authorization is obtained from me or unless the disclosure is specifically required or permitted by law.

## AUTHORIZATION TO RELEASE MEDICAL RECORDS (continued)

SPECIFY RECORDS:     Medical Information     X-Ray/Other Imaging

Psychiatric

\_\_\_\_\_

*Signature**Date*

Drug/Alcohol

\_\_\_\_\_

*Signature**Date*

HIV Test Results

\_\_\_\_\_

*Signature**Date*

Genetic Testing

\_\_\_\_\_

*Signature**Date*

Other (specify)

\_\_\_\_\_

\_\_\_\_\_

*Signature**Date*

REQUESTED RECORDS TO BE PROVIDED VIA:

PaperCD/Other Portable Storage

Electronically

I request that the health information released pursuant to this authorization be used for the following purposes only: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Patient/Guardian Signature*

\_\_\_\_\_

*Date*

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization and the copy is for me to keep.

\_\_\_\_\_

*Patient/Guardian Signature*

\_\_\_\_\_

*Date*

\_\_\_\_\_

*Relationship to Patient (if signed by other than Patient)*

CONFIDENTIAL INFORMATION MAY BE ACCESSED BY VISTA MEDICAL ASSOCIATES EMPLOYEES FOR PURPOSES OF PHOTOCOPYING INFORMATION IN RESPONSE TO PROPERLY AUTHORIZED REQUESTS FOR COPIES OF MEDICAL RECORDS.

YOUR RECORDS FOR **2 YEARS** IS ALL THAT WILL BE COPIED UNLESS OTHERWISE REQUESTED. THERE MAY BE A CHARGE FOR RECORDS OLDER THAN 2 YEARS

THE COPYING PROCESS USUALLY TAKES 15 WORKING DAYS. RECORDS WILL NOT BE FAXED.