

# Fresno Family Medical Clinic

Phone Number: 559-412-4927 Fax: 559-493-5028  
3121 E Olive Ave., Fresno CA 93702

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
to release all medical records and other information. Related to my treatment, hospitalization and out  
patient care to: Fresno Family Medical Clinic. This includes record related to drug or alcohol abuse,  
psychiatric, psychotherapy notes and HIV related (AIDS) diagnosis and/or rest results.

Please check appropriate records requested:

|                            |                             |
|----------------------------|-----------------------------|
| _____ All Medical Records  | _____ Physical Exam         |
| _____ Consults             | _____ X-ray and Lab Reports |
| _____ Immunization Records | _____ Others (Specify)      |
| _____ List of Medication   |                             |

Purpose of the information:

\_\_\_\_\_ Medical \_\_\_\_\_ Insurance \_\_\_\_\_ Legal \_\_\_\_\_ Personal \_\_\_\_\_ Other

I understand that this authorization: Requires Identification Verification with government issued ID.

- A. Prohibits further use or disclosure of the information being released beyond the specific limits of this consent.
- B. Expires six months from the date of signature until \_\_\_\_\_.
- C. This authorization may be revoked at any time.
- D. A photographic copy of the authorization shall be as valid as the original.
- E. A fee may be charged for copying cost.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_ Print: \_\_\_\_\_ Signature: \_\_\_\_\_