Truckee Tahoe Medical Group
www.ttmg.net

Mailing Address: 10115 W. River St
Truckee, CA 96161
530.581.TTMG

Authorization for Release of Medical Information

Patient's name: ______________________ Date of Birth: ______________
Address: ______________________
City/State/Zip Code: ______________________
Patient's phone #: (   ) ______________ **Date of Request:** ______________

❒ I authorize TTMG **to release information to**:

____
Name of Provider or Facility

____
Address

____
City, State, Zip Code

____
Phone #/Fax # (include area code)

***see below for fee information*

OR

❒ I authorize TTMG **to obtain information from**:

____
Name of Provider or Facility

____
Address

____
City, State, Zip Code

____
Phone #/Fax # (include area code)

Destination: ❒ Truckee Office (fax 530.587.0974)
❒ Tahoe City Office (fax 530.583.1826)

PURPOSE FOR THIS REQUEST: (Check one.) ❒ Healthcare ❒ Personal ❒ Other ❒ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)
❒ Administered by TTMG only. ❒ Include records submitted to TTMG.
❒ All medical records related to a specific illness or injury.

____
Specify illness/injury Date(s) of treatment

❒ Specific information (Select one or more, as applicable)
❒ Procedure report ❒ History & physical ❒ Immunization history ❒ Laboratory test results
❒ X-ray reports ❒ Other ______________________
(Please describe.)

❒ Entire copy of the record.

AUTHORIZATION VALID FOR: (Check one.)
❒ This request only.
❒ One year from the date of this authorization **OR** ______________ . (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.
❒ This request **and** for medical records of any **future** treatment of the type described above until: ______________
Insert Date

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There is a $20 processing fee to release your records and a $30 processing fee to release x-ray copies to another provider/facility.

Signature of Patient or Representative ______________________ Date ______________

Relationship to Patient *(if requester is not the patient)* ______________________