Authorization for Release of Medical Information

Fax completed form to (530)587-6730

Patient *Legal* Name: _____

Date of Birth: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

I Authorize Truckee Tahoe Medical Group to: (Check one): ☐ **Release records to: OR** ☐ **Obtain Records from:**

Authorized Recipient or Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

OR- *Mail* Medical Records to: Truckee Tahoe Medical Group 10956 Donner Pass Rd Suite #110 Truckee, CA. 96161

Health Information Requested:

☐ X-ray Image ($15.00 charge for a personal CD) ☐ Radiology Report

☐ Lab Results: → ☐ most recent or ☐ Specific year: _____ ☐ Immunization History

☐ Other_____ ☐ **Date(s) of service:** _____

OR ☐ ***ALL Records for the past 5 years ($20 administration fee)**

* *My records will not be processed until fee is paid.* *We accept cash, check or credit cards (*please call #530.581.8864 x 1)*

Method of Delivery: (to be completed only if patient is requesting record for themselves**)**

☐ Pick Up- specify which office: ☐ **Tahoe City** ☐ **Squaw Valley** ☐ **Truckee suite 360** ☐ **Truckee suite 110**

☐ E-mail (not secured & will only release records to email address on file)

☐ Mail via USPS

I understand that:

- This Authorization will become effective immediately and will expire on _____ [Date]. If no date is specified, this authorization will expire one (1) year from the signature date.
- I may revoke this Authorization at any time, in a written revocation sent to the Custodian of Records. However, I understand that my health information might have already been released.
- Information released by this Authorization might be re-disclosed by the recipient and might not be protected by state and federal privacy laws. I agree to release Truckee Tahoe Medical Group from liability for release and disclosure of the released information.
- I am aware Truckee Tahoe Medical Group will only release records ordered by their providers and I will need to obtain outside records on my own.

Patient/Representative Signature: _____

Print Name (If not patient): _____

Relationship to patient: _____ Date: _____

***Office use only*:**

***Payment received*: ☐ yes or ☐ no** ***Source:* ☐ cash ☐ check #_____ ☐ credit card**

***Amount Collected*: _____** ***Employee Initials*: _____**