WESTSIDE FAMILY HEALTH CENTER
a californiahealth+center

MEDICAL INFORMATION REQUEST/RELEASE

AUTHORIZATION TO RECEIVE MEDICAL INFORMATION

Patient Name:		Date of Birth:
Social Security Number:	Date(s) of Treatment Requested:	Type of Information Requested:

AUTHORIZATION

NAME OF HOSPITAL OR PHYSICIAN RECORDS ARE TO BE SENT FROM:

Name of Organization: _____

Address: _____

City/State/Zip: _____ Phone: (_____)_____

RECORDS TO BE SENT TO:

Westside Family Health Center
3861 Sepulveda Boulevard
Culver City, CA 90230
(310) 450-2191 Tel (310) 450-0873 Fax

RESTRICTIONS

I hereby consent to the release of any and all records containing:

- ☐ Alcohol and/or Drug Abuse
- ☐ Psychiatric Diagnoses
- ☐ Results of HIV tests performed
- ☐ All other medical information

(I understand that such information cannot be released without my specific consent, except in accordance with a court order.)

I understand that the recipient may not further disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

DURATION OF CONSENT

I hereby give my permission for a copy of my medical records, which are held at the above location, to be released to the Westside Family Health Center. This consent shall become effective immediately and shall remain in effect for twelve (12) months.

Date: _____ Patient Signature: _____

Date: _____ If signed by other than patient, Indicate relationship: _____

Date: _____ Witness: _____

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DURATION OF CONSENT

I hereby give my permission for a copy of my medical records, which are held at the above location, to be released from Westside Family Health Center. This consent shall become effective immediately and shall remain in effect for twelve (12) months.

Date: _____ Patient Signature: _____

Date: _____ If signed by other than patient, Indicate relationship: _____

Date: _____ Witness: _____