Date:_____ **Medical Records Release**

Last Name	First	MI	Date of Birth

Hereby authorizes:
Paul G Hovsepian, M.D.
11 E. Adams Ave
Alhambra, CA 91801
Phone: (626) 872-6215
Fax: (626) 872-2855

To Release Protected Health Information To:

Name of Facility/Health Care Provider

Street Address

City State Zip Code

Phone

Information to be Released:

- ☐ All Medical Records
- ☐ Vaccinations
- ☐ HIV/AIDS
- ☐ Radiology: XR, U/S, CT, MRI, Special Studies, etc.
- ☐ Progress Notes
- ☐ Consultations
- ☐ STD's
- ☐ Genetic Information
- ☐ Laboratory Tests
- ☐ EKG
- ☐ Mental Illness/Assessment
- ☐ Substance abuse
- ☐ Other: _____

From the period beginning: _____ (Date) to _____ (Date)

The purpose of the disclosure

Provide a description of the purpose of intended use and disclosure

I understand that health information used or disclosed as a result of my signing this authorization may not be further used or disclosed by the recipient unless permitted by law.

Expiration Date: / /

Your Rights With Respect To This Authorization:

Right to Receive a Copy of This Authorization

I understand that if I agree to sign this authorization, which I am not obligated to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization

I understand that I have the right to revoke this authorization at any time in written request. I also understand that it will not affect the ability of Stewart Medical Group or any health care provider to use or disclose the health information for reasons related to the prior reliance on this authorization,

Conditions

I understand that I may refuse to sign this authorization without affecting my ability to obtain treatment unless this authorization is related to research that includes treatment. If this authorization pertains to research treatment, I understand that I will not receive that treatment unless this form is not signed

I have read and understood the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Phone Number: _____

Patient Signature **Date**

Legal Guardian (if applicable) **Date**