## Medical Records Release

**Date:** _____

| **Last Name** | **First** | **MI** | **Date of Birth** |
|---|---|---|---|
| | | | |

**Hereby authorizes:**
**Stewart Medical Group**
1024 S. Garfield Ave.
Alhambra, CA 91801
Phone: (626) 289-5181
Fax: (626) 289-2725

**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
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ Vaccinations
- ☐ Consultations
- ☐ EKG
- ☐ HIV/AIDS
- ☐ STD's
- ☐ Mental Illness/Assessment
- ☐ Radiology: XR, U/S, CT, MRI, Special Studies, etc
- ☐ Other: _____

From the period beginning: _____ to _____
Date 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.**

_____ _____
**Patient Signature** **Date**

_____ _____
**Legal Guardian (if applicable)** **Date**