NORTHWEST MEDICAL GROUP
7355 N PALM AVENUE #100
FRESNO, CA 93711
(559) 271-6321 – FAX (559) 271-6326

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

NAME OF PATIENT: _____
(PLEASE PUT LABEL HERE)

DATE OF BIRTH: _____

INFORMATION TO BE RELEASED FROM: NAME: _____
ADDRESS: _____
_____

INFORMATION TO BE RELEASED TO: NAME: _____
ADDRESS: _____
_____

INFORMATION TO BE USED _____ **Only Northwest Med Grp records to other MD. No Charge (ONE TIME TRANSFER ONLY) SECOND TRANSFER $25.00 PRE-PAID**

FOR PURPOSE OF: _____ **For personal use $25.00 PRE-PAID**

TRANSFERRING **--------- YES -------- NO**

***ALL ALLOWABLE FEES FOR COPIES MUST BE PAID PRIOR TO MAILING RECORDS**

SEND THE FOLLOWING:

_____HISTORY/PHYSICAL _____X-RAY REPORTS _____EKG, TREADMILL

_____LAB REPORTS _____CONSULTATIONS _____MEDICATION LIST

I UNDERSTAND THAT THIS AUTHORIZATION:

1. Prohibits further use or disclosure of the information being released beyond the specific limits of this consent;
2. Includes all medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition.
3. Expires six months from the date of signature;
4. This authorization may be revoked at any time at my request;
5. I understand that I have a right to receive a copy of this authorization.
   _____Copy of authorization requested and received.

THANK YOU IN ADVANCE FOR YOUR PROMPT ATTENTION TO THIS REQUEST.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE