Release of Patient Medical Information

_____ *(Initial)* I give the physicians and staff of CBCC permission to discuss my treatment, diagnostic tests, medical condition with the following individuals:

_____ *(Initial)* I give the physicians and staff of CBCC permission to discuss my Mental Health Records protected by Lanterman-Petris –Short Act with the following individuals:

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone: _____

I understand that if I wish to add or delete individuals from this list that I must notify CBCC in writing.

I authorize CBCC to leave test results on my voice mail:

☐ Yes ☐ No

Home Phone: _____

Mobile Phone: _____

I authorize CBCC to fax test results to me:

☐ Yes ☐ No

Fax Number: _____

I understand that if my telephone or fax number changes from this list that I must notify CBCC in writing.

This is an indefinite consent form unless otherwise specified.

Date: _____

Patient Name: _____

Date of Birth: _____

Patient or Guardian Signature: _____

Guardian Name: _____

Relationship to Patient: _____