COMMUNITY Medical Centers

MEDICAL RECORDS REQUEST

PLACE LABEL HERE

Health Information Management: 209-546-3870
FAX: 209-762-6808
Email: myfaxmedrec@cmcenters.org

TO BE COMPLETED BY THE PATIENT OR THE PATIENT'S AUTHORIZED REPRESENTATIVE
ANY MISSING INFORMATION CAN DELAY PROCESSING

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

( ) _____
Telephone E-mail Address

I hereby authorize:

☐ Community Medical Centers, Inc., **or**

☐ _____
Provider or Organization Name

Street Address _____ City _____ State _____ Zip Code _____

( ) _____ ( ) _____
Telephone Fax Email Address

To release my confidential health information, as described below, to:

☐ Self ☐ Authorized designee

☐ Community Medical Centers, Inc.
PO Box 779 Stockton, CA. 95201 Fax: 209-762-6808 Email: myfaxmedrec@cmcenters.org

☐ _____
Provider or Organization

Street Address _____ City _____ State _____ Zip Code _____

( ) _____ ( ) _____ _____
Telephone Fax Email Address

In the following manner: ☐ Email ☐ Fax ☐ Pick-up Clinic *(if checked)* Location: _____

☐ Other: _____ Note: *Please Do Not send records via CD*

For the following purpose(s): ☐ At the request of patient ☐ Other: _____

My authorization is for the use and disclosure of the following records:

☐ Progress Notes, from dates: _____ to _____
☐ Medication List, from dates: _____ to _____
☐ Hospital Admission and/or ER Records, from dates: _____ to _____
☐ Radiology Reports, from dates: _____ to _____

Please turn over for page 2

☐ Laboratory Results, from dates: _____ to _____
☐ Billing Statements, from dates: _____ to _____
☐ Complete Immunization Record, from dates: _____ to _____
☐ Dental Records, from dates: _____ to _____
☐ Other records not listed (specify): _____

I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment information _____ (initials) dates: _____ to _____
☐ HIV test results & treatments _____ (initials) dates: _____ to _____
☐ Alcohol/drug treatment information _____ (initials) dates: _____ to _____

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

My authorization is given freely with the understanding that:

- I may revoke this authorization in writing at any time, except where information has already been released in reliance on my authorization.
- Unless specific dates are requested above, no more than 2 years of records will be sent when requesting "any or all" records.
- CMC may not condition my treatment on the provision of this authorization.
- Information disclosed under this authorization may be subject to re-disclosure by the recipient without further protection of confidentiality.
- A photocopy or fax of this authorization is as valid as the original.

Please allow a minimum of 15 days for records to be copied and made available.

This authorization will expire on: _____ (if not specified, valid for 1 year from date signed below)

_____
Patient's Signature Date

_____
Name of Parent or Personal Representative (please print) Date

_____
Description of Personal Representative's Legal Authority to Act on Behalf of Patient

FOR CMC STAFF USE ONLY

Verification of Identity

Requestor's identity verified by:

☐ verbal statement of patient's name, address, DOB
☐ comparison of patient's stated name, address and DOB with medical record
☐ copy of the authorization form provided

_____
Printed Name and Signature of CMC Staff Title Date