AUTHORIZATION TO RELEASE MEDICAL RECORDS

First Name	MI	Last Name	
Date of Birth	Social Security Number	Phone Number	
Street Address	City	State	Zip Code

This authorizes my medical records to be released from:	This authorizes my medical records to be released to: **Genesis/Unio Healthcare Partners**
_____ Name of Clinic/Physician	_____ Name of Clinic/Physician **20911 Earl Street, Suite 140**
_____ Address	_____ Address **Torrance, CA 90503**
_____ City, State, Zip	_____ City, State, Zip **310-542-0199**
_____ Phone	_____ Phone **310-542-4652**
_____ Fax	_____ Fax

NOTE: FEES MAY APPLY TO CERTAIN REQUESTS.

TYPE OF INFORMATION TO BE RELEASED

I request and authorize the release of the following information contained in my chart. This may include current and previous medical records from other practices and practitioners, hospitals and/or clinics which are part of my medical records.

☐ Complete Chart ☐ Consultation/Progress Notes ☐ Laboratory Records
☐ Procedure Reports ☐ X-Rays
☐ Other: _____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of the signature if no date entered.

REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

REDISCLOSURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). I hereby release the facility from any liability, which may arise as a result of the use of the information contained in the records released.

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

_____ _____

PATIENT SIGNATURE **DATE**