Graybill Medical Group
www.graybill.org

AUTHORIZATION TO RELEASE MEDICAL RECORDS
(Page 1 of 2)

Phone: (760) 291-6708
Fax: (760) 291-6889

Patient Name	Patient Date of Birth

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I hereby authorize the disclosing physician or health care provider noted below to release medical information to the receiving physician or health care provider indicated:

FROM:

_____
(Disclosing physician or provider)

_____
(Street Address)

_____
(City, State, Zip Code)

TO:

Graybill Medical Group
(Receiving physician or provider)

225 E. 2nd Avenue
(Street Address)

Escondido, CA 92025
(City, State, Zip Code)

Release records and information regarding: _____
(Patient's Name)

_____ _____ _____
(Date of Birth) *(Social Security #)* *(Telephone Number)*

_____
(Address, City, State, Zip Code)

DURATION: This Authorization shall become effective immediately and shall remain in effect through _____ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requestor may not lawfully further use or disclose the health information unless another Authorization is obtained from me or unless the disclosure is specifically required or permitted by law.

AUTHORIZATION TO RELEASE MEDICAL RECORDS (page 2 of 2)

SPECIFY RECORDS: ☐ **Medical Information** ☐ **X-Ray/Other Imaging**

☐ **Psychiatric** _____ _____
Signature ***Date***

☐ **Drug/Alcohol** _____ _____
Signature ***Date***

☐ **HIV Test Results** _____ _____
Signature ***Date***

☐ **Genetic Testing** _____ _____
Signature ***Date***

☐ **Other (specify)** _____

_____ _____
Signature ***Date***

REQUESTED RECORDS TO BE PROVIDED VIA: ○ **Paper** ○ **CD/Other Portable Storage**
○ **Electronically via NextMD**

I request that the health information released pursuant to this authorization be used for the following purposes only: _____

_____

_____ _____
Patient/Guardian Signature ***Date***

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

_____ _____
Patient/Guardian Signature ***Date***

_____
Relationship to Patient (if signed by other than Patient)

CONFIDENTIAL INFORMATION MAY BE ACCESSED BY BACTES CORPORATION EMPLOYEES FOR PURPOSES OF PHOTOCOPYING INFORMATION IN RESPONSE TO PROPERLY AUTHORIZED REQUESTS FOR COPIES OF MEDICAL RECORDS.

YOUR RECORDS FOR **2 YEARS** IS ALL THAT WILL BE COPIED UNLESS OTHERWISE REQUESTED. THERE MAY BE A CHARGE FOR RECORDS OLDER THAN 2 YEARS

THE COPYING PROCESS USUALLY TAKES 15 WORKING DAYS. RECORDS WILL NOT BE FAXED.