



**AUTHORIZATION TO RELEASE
MEDICAL RECORDS
(Page 1 of 2)**

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

Patient Name	Patient Date of Birth
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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:	TO: Graybill Medical Group
_____	_____
<i>(Disclosing physician or provider)</i>	<i>(Receiving physician or provider)</i>
_____	225 E. 2nd Avenue
<i>(Street Address)</i>	<i>(Street Address)</i>
_____	Escondido, CA 92025
<i>(City, State, Zip Code)</i>	<i>(City, State, Zip Code)</i>

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

_____	_____	_____
<i>(Date of Birth)</i>	<i>(Social Security #)</i>	<i>(Telephone Number)</i>

<i>(Address, City, State, Zip Code)</i>		

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.

REVOCAION: 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.

REDISCLASURE: 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.

