Encinitas Family Care
Phone: 760.274.1385 Fax: 760.274.1388 www.encinitasfamilycare.com

***ALL** HIGHLIGHTED AREAS MUST BE COMPLETED IN ORDER TO RELEASE RECORDS.*

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: ______________________________ Date of birth: __________ Date: ______________

Phone: (______) ______________________________ Email address: ____________________________

I, (print name) ______________________________________ hereby authorize Encinitas Family Care to release my health record information as specified below:

Purpose: Continuation of Care Personal Use Insurance Other
Method: MAIL FAX
I authorize the release of the following information: (check boxes that apply)

☐ Dates requested: ____
☐ Other Non-EFC records

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information released may be subject to re-disclosure by the person or class of persons or facility receiving it, and that at privacy laws may no longer apply. I understand the information in my health record may include information relating to sexually transmitted disease,acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Release my health record information to:
Name: ____________________________________ **Address:** ____________________________________
Relationship to patient: ______________________ **City:** __________________ **St:** ______ **Zip:** __________
Fax: (____) ________________________________ **Phone: (____)** __________________________________

Signed: ____ Date: ________________
Patient or legally authorized individual

If signed on behalf of the patient: Print your name: ____________________________________

Describe your authority to act on behalf of the patient:
☐ Parent or legal guardian (if patient is a minor) ☐ Durable power of attorney for healthcare
☐ Court-appointed personal representative ☐ Other: ___________________________

Witness: ____ Date: _______________

Verified Photo ID: ___________