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Goleta, CA 93117
Tel (805) 681-7411• Fax (805) 681-7410

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Santa Barbara, CA 93105
Tel (805) 682-7411• Fax (805) 682-6933

319 N. Milpas
Santa Barbara, CA 93103
Tel (805) 965-3011• Fax (805) 965-3441

# Authorization for Release of Information (HIPAA compliant)

***The patient is to complete this form in its entirety in order for The MedCenter to release or request any medical information. The patient must be specific as to the nature of the information to be released and the purpose for which it is requested. The patient is entitled to receive a copy of this release. This authorization shall be valid for one year from the date when it was signed.***

Patient Name:________________________________________DOB:__________SS#________

Information to be released from: The MedCenter, Inc. or______________________
Name of individual or Agency

Information to be released/sent to: ________________________________________
Name of Designated Recipient

________________________________________
Address

________________________________________
City, State, Zip Code

________________________________________
Phone Number Fax Number

Information to be released/disclosed:

______All Medical Records
______Specific information(please specify)____________________________
____________________________
______Records/information for treatment of a work related injury or illness

Purpose for which disclosure is being made:__________________________________________

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. **EXCLUDE** the following information from the records released (*please initial*):

_____Drug/Alcohol abuse treatment & diagnosis_____Sexually transmitted diseases
_____HIV/AIDS diagnosis/treatment/testing _____Mental Illness or psychiatric diagnosis /treatment

My Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to Patients posted at the front desk. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature:______________________________________Date:_________________________