CHOICE MEDICAL GROUP
19111 Town Center Drive, Apple Valley, CA 92307
Phone: (760) 242-7777 Ext 285 Fax: (888) 633-2996

# Consent to Release Medical Records

Patient Name: _____ DOB: _____

Address:_____ Phone:_____

1. I hereby request and authorize Choice Medical Group to:

   ❒ Release Information **TO** ❒ Obtain Information **FROM**

2. Name of Provider/ Facility _____
   Address _____
   Telephone:_____ Fax: _____

3. The PURPOSE of this release is: (check all that apply)
   ❒ Moving ❒ Insurance Purposes ❒ Transferring Care ❒ Second Opinion
   ❒ Personal Review ❒ Other (please specify) _____

4. The FOLLOWING Protected Health Information (PHI) may be released:
   (Please check one)

   ❒ I consent to the release of **all medical records** including records, Physician consult notes, x-ray reports and lab tests. (This release **excludes** any records transferred to Choice Medical Group from previous care providers).

   ❒ I consent to the release of **all medical records** with the following treatment or condition with the exceptions of:

   _____
   _____

   ❒ I consent to the release of **all medical records** from _____ (date) to _____ (date).

5. **This authorization will automatically expire within one year from the date of signature.** I understand that I have the right to revoke this authorization in writing at any time, except where information has already been released in response to this authorization.

**NOTICE TO PATIENT:** There is a $15.00 processing fee and $0.10/page fee for any medical records that are requested for personal reasons. NO charge for records sent to another provider.

Signature of Patient/Representative/Legal Guardian:

_____ Date:_____

Witness:_____ Date:_____

Medical Records
Department Only

Date Received:_____
Date Completed:_____
Fee:_____Initials:____