RIALTO UNIFIED SCHOOL DISTRICT
HEALTH SERVICES
815 S. Willow Avenue, Rialto, CA 92376 • Tel (909) 820-8150 • Fax (909) 820-8151

MEDICAL REQUEST DEPARTMENT
Authorization for Release and/or Disclosure of Medical Information

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

PLEASE REQUEST MEDICAL INFORMATION FROM:

_____

_____

_____

PLEASE SEND MEDICAL INFORMATION TO:

_____
Name of Person or Entry to Receive Information

_____
Title (Physician, Therapist, Attorney)

_____
City, State and Zip Code

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Release and/or disclose records and information regarding:

_____ _____ _____
Name of Patient (List Other Names Used) Medical Record Number Date of Birth

_____ _____ _____ _____
Address City State Zip Code Telephone Number

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

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDIS-CLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFICE RECORDS TO BE RELEASED AND/OR DISCLOSED:

Check the box and initial which type of information is to be release and/or disclosed:

☐ General Medical Information (From: _____ To: _____)

☐ Information regarding Specific injury or treatment (From: _____ To: _____)

☐ X-Ray (check one or both): ☐ Films ☐ Reports

☐ Laboratory Results

☐ Mental Health (From: _____ To: _____) _____
Signature of Patient or Patient's Representative/Date

☐ Alcohol/Drug (From: _____ To: _____) _____
Signature of Patient or Patient's Representative/Date

☐ HIV Test Results (From: _____ To: _____) _____
Signature of Patient or Patient's Representative/Date

☐ Other (specify): _____

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purpose only: _____

_____

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

_____ _____ _____
Date Signature of Patient or Patient's Representative Indicate Relationship (if signed by other than Patient)