ASSOCIATED FAMILY PHYSICIANS

8110 Timberlake Way
Sacramento, CA 95823
(916) 689-4111

417 C Street
Galt, CA 95632
(209) 745-1778

www.familymd.com

Authorization for Records Release

I hereby authorize: _____

_____

_____

To disclose to: Associated Family Physicians
8110 Timberlake Way
Sacramento, CA 95823

Records & Information Pertaining to:

_____ _____

Patient's Name **DOB**

For the reason of:

_____

_____

_____

_____

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here. _____

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

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

_____ _____

Patient's Signature **Date**