West Marin Medical Center
MARIN HEALTHCARE DISTRICT

Authorization for Release of Medical Records

PATIENT INFORMATION			
Patient's last name:	First:	Middle:	Birth date:
Street Address:			Phone:
City/State/Zip Code:			

RELEASE RECORDS FROM	RELEASE RECORDS TO
Name:	Name:
Address:	Address:
Phone:	Phone:

REASON FOR RELEASE

This information is needed for the following reason(s):

INFORMATION TO RELEASE

The specific information I wish to have released is (included dates of treatment):

SENSITIVE HEALTH INFORMATION

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

☐ I DO consent to have this information disclosed.
☐ I DO NOT consent to have this information disclosed.

This medical record may contain information concerning HIV testing and / or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

☐ I DO consent to have this information disclosed.
☐ I DO NOT consent to have this information disclosed

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

Patient/Guardian signature *Date*

Witness *Date*