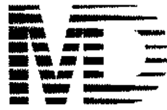

Mobile **Doctor** Medical Clinic
In-home medical services

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Rancho Santa Fe Medical Group, Inc. and Mobile Doctor Medical Clinic, 1582 W. San Marcos Blvd., Suite 100, San Marcos, CA 92078-4081
Tel: (760) 591-9975, Fax: Tel: (760) 591-9976.

To Release Information to or Obtain Information From:

Name: ____________________

Address: ____________________

____

Tel: ____________________ Fax: ____________________

The Medical Records For:

Name: ____________________

Date of Birth: ____________________ Social Security: ____________________

Disclosure is Necessary for the purpose of ____________________ and that purpose only. I understand that this authorization extends to all or any part of the records information designated below, which may include treatment, physical and mental illness, alcohol, drug abuse; HIV/AIDS test results or diagnosis. The information to be released includes (please check records to be disclosed pursuant to this authorization):

______ Complete Chart
______ Treat
______ Lab
______ Xray
______ Discharge

______ Mental
______ Progress
______ Phys. Notes
______ Med

______ Verbal Discussion with
____
______ Bill Info
______ Other ____________
____

The treatment dates covered by this authorization are from pre admission to discharge and claims resolution. In any event, I may revoke this authorization at any time, except to the extent that action has been taken in reliance thereon. Authorization will automatically expire 60 days from the date or by my written request. I release Rancho Santa Fe Medical Group, Inc. dba Mobile Doctor Medical Clinic from all legal responsibilities or liability that may arise from disclosure of medical records in reliance on this authorization. If the patient is a minor both the patient and the parent or guardian must sign the authorization. A facsimile or photocopy or this authorization may be accepted in lieu of the original.

____
Patient/Parent/Guardian **Print Name** **Date**

____
Staff Member/Witness Signature **Print Name** **Date**

Revocation: I have the right to stop this release of information at any time. Although I do understand that RSFMG/Mobile Doctor cannot do anything about information already disclosed under this authorization, I no longer want any more information disclosed and I am revoking my authorization as of the date listed below.

____
Signature **Date**

www.sandiegomobiledoctor.com