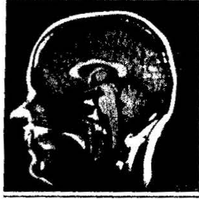

San Jose Pacific Neurology Center
Professional Corporation

REQUEST FOR RELEASE OF MEDICAL RECORD INFORMATION

PATIENT IDENTIFICATION

Name: ______________________________ DOB: ____________

Address: ______________________________

Social Security #: ______________________________ Phone: ____________

I request and authorize San Jose Pacific Neurology Center, located at 200 Jose Figueres Avenue, Suite 200, San Jose, CA 95116 -- P (408) 347-1600 F (408) 347-0600, to release my medical records to:

Physician or medical facility: ______________________________

____
Address

PERTAINING TO:

Treatment dates: ______________________________

All medical records: ____________ Emergency room record: ____________

MRI of brain/spine/other neuroimaging: ____________ History & Physical exam: ____________

Laboratory tests: ____________ Consultation: ____________

Other: ______________________________

TIME LIMIT AND RIGHT TO REVOKE AUTHORIZATION

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility. Unless revoked, this authorization will expire on the following date or event: ____________
or one year from the date of signature unless otherwise specified.

RE-DISCLOSURE

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extend indicated and authorized herein.

DRUG/ALCOHOL ABUSE, PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE

☐ Yes ☐ No I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

☐ Yes ☐ No I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

SIGNATURE OF PATIENT OR REPRESENTATIVE WHO MAY REQUEST DISCLOSURE

I can inspect or copy the protected health information to be used or disclosed. I authorize San Jose Pacific Neurology Center to use and disclose the protected health information specified above.

______________________________ ____________
PATIENT'S SIGNATURE (OR REPRESENTATIVE) DATE

______________________________ ____________
PERSONAL REPRESENTATIVE (PLEASE PRINT) RELATIONSHIP