PLACER PRIVATE PHYSICIANS

Personalized family and sports medicine

Placer Private Physician Authorization for Release of Medical Records

Previous Physician/Clinic Phone Number/Fax

Street Address

City, State, Zip

NOTICE:
Physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidential law may no longer protect it.

DISCLOSURE:
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.

YOUR RIGHTS:
This authorization to release health information is voluntary. The authorization shall become effective immediately and shall remain in effect one-year from the date of signature unless different date is specified here _____. Treatment, payment, enrollment of eligibility from benefits many not be conditioned on signing this authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entities obligation to pay a claim, or (4) to create health information to provide to third party. This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Placer Private Physicians, Inc. The revocation will take effect the date we receive it. You are entitled to receive a copy of the authorization if you request it.

By signing below I hereby authorize the release of my medical records to the following physicians:

Brön Hedman, M.D.
Richard Lichti, M.D.
Lezley Brown, M.D.
Placer Private Physicians
6960 Destiny Drive, Suite 100
Rocklin CA 95677
Phone: (916) 624-1777
Fax: (916)624-1770

Specify Records:

☐ Medical Information

Signature Date

☐ Other Health Information (specify the records to be disclosed)

Specify records to be disclosed

Print Name **Birthday**

Signature (Patient/Parent/Guardian) **Date**

If signed by other than patient, indicate relationship