Santa Clara Family Health Plan™

General Authorization for Release of Medical Records

______________________ Name of Patient

______________________ Date of Birth

______________________ Social Security #

1. *I hereby authorize* ____________________________________ (M.D., agency or institution) to furnish medical information concerning the above named patient to:

   ____
   (Name & address of receiving person or institution)

2. *I authorize* the information may be used only for the following purposes:

   ____

   ____

3. *I authorize* the following persons or entities to have access to the above information:

   ____
   (Name or function of the persons or entities authorized to have access to the above medical information)

4. *I specifically direct that* NONE of the following information be released (if applicable):
   - ☐ **Mental health records**
   - ☐ **Drug and alcohol abuse records**
   - ☐ **HIV/AIDS test results**
   - ☐ **Genetic test results**
   - ☐ **Other:** ____

5. *I understand* that I have the right to receive a copy of this authorization. This authorization to release records is effective ______________________ (today's date), and will remain effective for sixty (60) days from this date.

Patient Signature:____ **Date:**______________________

Parent/Guardian/Conservator Signature:______________________ **Date:**______________________

Print Name:____

Please indicate relationship:
- ☐ Parent or guardian of minor patient
- ☐ Guardian/conservator of an incompetent patient
- ☐ Beneficiary/personal representative of deceased patient

40109

(Pursuant to Civil Code 56.11)