BASS Medical Group-Neurology

Dr. Raymond Stephens, Dr. Robert Algar, Dr. Steven Schadendorf
Dr. Leslie Gillum, Dr. Melissa Lehmer, Dr. Negar Sodeifi, Dr. Caroline Perry
Dr. Okkyung Kim, Dr. Kai C. Lee, Erik Kuecher PA & Jasmine Bhasin PA
400 Taylor Blvd, Suite 301 • Pleasant Hill, CA 94523
(925) 602-7060 • FAX: (925) 602-7070

AUTHORIZATION FOR ***RELEASE*** OF PATIENT HEALTH INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information regarding my medical history, illness or injury, consultations, prescriptions, treatment, diagnosis or prognosis, correspondence and/or medical records those from my other health care providers that the above named health care provider may hold.
Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization*

Patient Name (first middle last): _____
Date of Birth: _____
Physican:_____

Records release information (Record will be released to BASS Medical Group-Neurology) or
Name of Requestor: _____ Phone: _____
Address:_____ Fax: _____
City_____ State_____ Zip code _____
Relationship to patient: □ Patient □ Parent of Minor □ Legal Guardian □ Power of Attorney
□ Patient Authorized Representative □ Executor of Estate □ Representing Attorney

Format of records
□ In Person □ Mail (address from section B) □ CD copy □ Paper Copy
□ Fax (fax from section B) □ Email (email from Section B)

Limitation on the type of information to disclose:
□ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
□ Limited to the following records (specify record): _____

I also consent to the specific release of the following records:
Drugs/Alcohol/Substance Abuse _____ (initial)
Tests for Antibodies to HIV _____ (initial)
Psychiatric/Mental Health _____ (initial)
HIV Diagnosis/Treatment _____ (initial)
Genetic Information _____ (initial)

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DURATION

This authorization shall be effective immediately and remain in effect until _____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient *or legal/personal Representative patient*
Relationship *if other than*

_____ _____
Patient's Name (PRINT)
Date

_____ _____
Patient's Social Security Number
Patient's Date of Birth

_____ _____
Witness name
Witness signature