RELEASE OF CLIENT/RESIDENT MEDICAL INFORMATION

To: _____ Date: _____
(PHYSICIAN, CLINIC, HOSPITAL, HOSPICE, HOME HEALTH AGENCY, ATTENDING NURSE, PSYCHOLOGIST, COUNSELOR, THERAPIST, ETC.)

_____
(ADDRESS)

I hereby authorize you to release any and all medical or confidential information contained in the record of:

_____
(NAME OF PERSON)

_____
(NAME AND ADDRESS OF FACILITY, PERSON OR AGENCY REQUESTING INFORMATION)

THIS AUTHORIZATION SHALL EXPIRE ON: _____
(DATE)

_____
(CLIENT OR AUTHORIZED REPRESENTATIVE)

_____
(RELATIONSHIP TO PERSON ON WHOM INFORMATION IS REQUESTED)

_____
(ADDRESS)

NOTE:

1. The person who authorized this release may revoke this authorization at any time.
2. The person who authorized this release has a right to receive a copy of the release.
3. This information is required to conform to CCR Title 22 regulations, to ensure a continuum of care to the resident, client or child. Licensees should maintain a copy of this form in the facility records.
4. The above facility is licensed by the Department of Social Services (or its accredited agencies), and does not provide skilled nursing care.