Optum–San Bernardino

Authorization for release and/or disclosure of medical information

I hereby authorize the person/entity below to release and/or disclose of my individually identifiable protected health information ("PHI") in the manner described below. I understand that the recipient of my PHI may not further disclose the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. I further understand that the health care provider will not condition the provision of care or the receipt of benefits on the signing of this authorization. *** Records over 10 pages are subject to a processing fee ***

Request records from:	**Send records to:**
Optum–San Bernardino 1700 N. Waterman Ave. San Bernardino, CA 92404 Phone: **1-909-883-8611,** TTY **711** Fax: **1-909-881-5707**	__________ Name of person/facility receiving records __________ Street address __________ City/State/Zip code __________ Area code and phone number

Name of patient: __________ Date of birth: __________

Address: __________ City/State/Zip code: __________

Telephone number: __________

Duration: This authorization shall become effective immediately and shall remain in effect until __________ (enter date) or for six months from the date of signature if no date entered.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Specify records to be released and/or disclosed

General medical records may include references or referrals to mental health, alcohol and drug treatment, if noted by my provider, but not the actual medical records themselves, unless specifically requested below.

- ☐ All general medical information, or
- ☐ General medical information: From ______ to ______
- ☐ Laboratory results: From ______ to ______
- ☐ X-ray results: From ______ to ______
  ☐ report and/or ☐ films (check one)
- ☐ Mental health records: From ______ to ______ Initial ____
- ☐ Alcohol/drug: From ______ to ______ Initial ____
- ☐ HIV test results: From ______ to ______ Initial ____
- ☐ Claims/billing: From ______ to ______
- ☐ Outside records: From ______ to ______
  Name of person or facility: __________

__________ __________ __________

Signature of patient, parent or guardian **Indicate relationship** **Date**

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