A Division of BASS Medical Group
112 La Casa Via Suite #300 Walnut Creek, CA 94598
Phone: 925-239-0012 Fax: 925-239-0011

Authorization for Release of Medical Information and Protected Health Information

Name: _____ DOB: _____
Last First Middle

E-mail: _____ Phone # _____

I, hearby authorize Rose, Senior, Vemulapalli Physicians to disclose my medical information to:

Facility Name _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Information to be disclosed:

This authorization permits the above named health care provider to disclose the following medical records:

☐ All my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes, billing information, correspondence, and records from my other healthcare providers that the above-named health care provider may hold.

☐ All my healthcare information described above *except* for the following:

_____

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

A $20.00 records copy fee will apply. You may pay by check or cash. Records will be sent within 10 days of receipt of payment and signed Request for Release of Medical Records form.

Patient Signature: _____ Date: _____