University of the Pacific

Authorization for Release of Medical Information

I, _____ (patient), hereby authorize _____ (physician/practitioner), to release personal health information, including that required on the Certification of Physician or Practitioner, if attached. This information will be provided to: _____
Company Name

for the purpose of:

_____
(specific purpose for which information is to be used)

The type of information that may be released and used by the Company includes:
(Check where applicable and include dates as appropriate.)

- ☐ Certification of Serious Health Condition, as required for leave under federal or state law
- ☐ Medical information related to the disability of _____
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization record
- ☐ Most recent history or physical exam results
- ☐ Most recent discharge summary and/or statement of limitations
- ☐ Other (specify) _____

_____

This authorization is valid from _____ (start date) to _____ (end date). If I fail to specify an expiration date, this authorization expires in 90 days after the date of my signature below unless previously revoked in writing. I understand that I have the right to revoke this authorization at any time by giving a written notice to the Company or the provider/practitioner named above. Such revocation shall not apply to any information that has been released prior to revocation of this authorization.

I understand that authorizing the disclosure of my medical information is voluntary. I can refuse to sign this authorization. I further understand that I have the right to inspect and copy the information disclosed as a result of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, which may or may not be protected by federal or state confidentiality rules. If I have any questions about the disclosure or use of this information, I may contact: _____
Name of privacy officer/official responsible for health information privacy

_____ _____
Signature of Patient or Legal Representative of Patient Date

If signed by Patient's Legal Representative, describe your (legal representative's) authority to act:

_____

_____