ROSE AVENUE FAMILY MEDICAL GROUP

Josephine Soliz, M.D.
John Ford, M.D.
Maria del Rocio Villasenor, M.D.
Kristen Anderson, M.D.
Autumn Edwards, M.D.
Rosalva Romero, FNP/PA
Mariela Varis, M.D.
Helen Ashton, M.D.

Board Certified Family Practice
451 W. Gonzales Rd, STE 230, Oxnard, CA 93036
Tel. (805) 988-1443 / Fax: (805) 988-0897

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:____ DOB:______________

Address:____

City:______________________________ State:______________ Zip:______________

SSN:__________________ Daytime Phone:__________________ Cell Phone:__________________

I authorize you to OBTAIN Healthcare Information FROM:

____
Physician/Hospital Name:

____
Address:

____
City/State/Zip

______________ ______________
Phone #: Fax #:

I authorize you to SEND/DISCLOSE Health Care Information TO: ( ) PICK UP

____
Name:

____
Address:

____
City/State/Zip

______________ ______________
Phone #: Fax #:

SPECIFY RECORDS. Check the box in which type of information is to be disclosed. Check all that apply and sign.

( ) ALL MEDICAL INFORMATION

Signature:______________________________

( ) PSYCHIATRIC INFORMATION

Signature:______________________________

( ) DRUG/ALCOHOL

Signature:______________________________

( ) HIV TEST RESULTS

Signature:______________________________

( ) OTHER – Specify:____

REASON FOR DISCLOSURE

( ) CHANGE OF DOCTOR ( ) REFFERAL OR SECOND OPINION ( ) INSURANCE APPLICATON/BENEFITS

( ) OTHER – Specify:____

DURATION: REVOCATION: REDISCLOSURE:	This authorization shall become effective immediately and shall remain I effect until:______________________ (enter date) or for one year from the date of signature if no date entered. Disclosure of information by the disclosing party. Written revocation will be effective upon receipt but will not be effective to the extent that the requester or others have acted in reliance upon this authorization. I understand the requester may not lawfully further use or disclose the health information unless another authorization is obtain from me or unless disclosure is specifically required by law.

A copy of this authorization is valid as original.

______________________________ ______________
Signature of Patient or Patient's Representative Date:
Indicate Relationship (if signed by other than Patient):______________________________