

WORKING WONDERS  
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____			
Last	First	MI	
Patient Social Security Number: _____ - _____ - _____ Home Phone Number: _____			
I hereby Authorize _____ ( ) _____			
Name		Phone	
Address _____ City _____ State _____ Zip _____			
<input type="checkbox"/> To obtain my information      OR <input type="checkbox"/> Release my information to:			
_____ ( ) _____			
Name		Phone	
Address _____ City _____ State _____ Zip _____			

Dates of Services requested: _____		
This authorization is for <b>full</b> disclosure of all records, including:		
<input type="checkbox"/> ER Records	<input type="checkbox"/> OP Reports	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> H&P	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Consults	<input type="checkbox"/> Cardiology	<input type="checkbox"/> Mental Health Information
<input type="checkbox"/> HIV Information	<input type="checkbox"/> Drug/Alcohol Information	<input type="checkbox"/> Other: _____
The above information is released for the following purpose and that purpose only:		
<input type="checkbox"/> Continuation of care	<input type="checkbox"/> Legal Purposes	<input type="checkbox"/> Insurance Purposes
<input type="checkbox"/> Personal Reasons	<input type="checkbox"/> Employee Recruitment	
<input type="checkbox"/> Other: _____		

<input type="checkbox"/> FAX (760) 324-6909
<input type="checkbox"/> Mail P.O. BOX 3698 Cathedral City, CA 92235-3698

