



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Last Name _____ Patient First Name _____ MI _____
Patient Date of Birth ____/____/____

My records are to be released from:

Previous Facility's / Doctor's Name _____
Telephone # (____) _____ Fax # (____) _____
Address _____ City _____ State _____ Zip _____

My records are to be released to:

Facility's / Doctor's Name Edge Family Medicine (Mike Zuniga MD & Darlene Espinosa MD)
Telephone # (909) 870-5200 Fax # (909) 858-1330
Address 440 N Mountain Ave. Suite 110 City Upland State CA Zip 91786

The records to be release are (please specify dates and type of records):

From _____ To _____
 All Medical Records Lab Reports
 All Medical Records; Last 2 years only X-Ray Reports
 History and Physical Exams Consult Reports
 Other: _____

My records are to be released for the following purpose:

Changing Physicians Continuing Care Insurance
 Other: _____

Genetic testing, HIV, behavioral health or drug and alcohol abuse/treatment information within the requested dates will be included unless specified below:

DO NOT RELEASE (CHECK ALL THAT APPLY): __Genetic Testing __HIV __Behavioral Health __Drug/Alcohol

I may revoke this authorization at any time unless the recipient has already processed this request.
To revoke this Request: send a written notice to the place where this authorization was signed.
I May not be required to sign this authorization as a condition to receiving treatment, payments or benefits.
The recipient of the records is prohibited from re-disclosing the information without receiving a new request for disclosure or if required or permitted by law. A photocopy of this form will be considered as valid as the original.

**This authorization will expire 90 days from signing.
I HAVE READ AND UNDERSTAND THE ABOVE.**

Patient Name _____ Date ____/____/____
Patient Signature _____ Date ____/____/____
Parent/Legal Guardian Name _____ Date ____/____/____
Parent/Legal Guardian Signature _____ Date ____/____/____