ELITE FOCUS CLINIC
881 Fremont Ave, Suite A3, Los Altos, CA 94024
https://www.elitefocusclinic.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

SECTION I – Patient Information

Patient Name	Date of Birth MM DD YYYY	Telephone Number
Street Address	City, State,	Zip

SECTION II – Health Information

I hereby authorize and request _____ [PROVIDER'S NAME] and office staff at Elite Focus Clinic to release or receive confidential information including my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions, including records related to:

Initial each to approve release: **____ Mental Health ____ Alcohol/Drug Abuse Treatment ____ Genetic Information**

____ Communicable Diseases including but not limited to HIV/AIDS

SECTION III – Recipient Information

Individual/Organization Name		Telephone Number
Street Address	City, State, Zip	Fax Number

_____ (*please initial***)** I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

SECTION IV – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write '*at my request*':

_____

SECTION V – Revocation

I understand that I am permitted to revoke this authorization to share my health data at any by notifying, in writing, the [CENTER NAME]. I further understand that:

- If my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in Section III.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

SECTION VI – Signature

By signing my name below, I certify that this information can be used for the purpose of processing my Authorization for Release of Medical Information request.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship to Patient

_____
Patient Representative's Authority to Act for Patient (*attach supporting documentation*)