

# Harbor Medical Associates, Inc.

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## AUTHORIZATION FOR RELEASE OF INFORMATION

*Medical, Psychiatric and Substance Abuse Records*

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Social Security # \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_

Obtain Records From	Send Records To	Name of Individual Organization	Address	Phone Number	Fax Number	Relationship to Patient

**Rights & Restrictions:** I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or obtain a copy of this authorization to be used and/or disclosed under this authorization in accordance with organizational policy. Photocopy/Fax may be used as original. I understand I have the right to revoke this authorization in writing at any time or change what information to be released. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

*Under California Law, however, a recipient of medical information, whether disclosed pursuant to an authorization or to the discretionary provisions of California Civil Code #56.10(x) may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.*

I, \_\_\_\_\_ (*name of Patient/Guardian*), hereby authorize **HMA, Inc.** to disclose information and records obtained in the course of my diagnosis and treatment for the following purpose: to obtain previous medical/ psychiatric history, assist in diagnosis and treatment and to coordinate care on an ongoing basis with my other providers.

\_\_\_\_\_  
**Patient/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Date**