Cannamed of Thousand Oaks a
California Medical Corporation

Authorization for Release of Health Information

Patient Name: _____
Date of Birth: _____
Patient Address: _____
Street

City **State** **Zip Code**
Phone Number: _____

Medical Record Number: _____

I authorize the below named Provider to release health my medical information :

Street Address, City, State, Zip Code:

Phone number: Fax number:

Name of person or facility to receive health information:
Cannamed Medical Corporation - Framingham Office

Specify name/title of person to receive health information, if known:
Medical Records Department

INFORMATION TO BE RELEASED

☐ Discharge Summary	☐ Laboratory Reports	☐ Emergency Medicine Reports
☐ Billing Statements	☐ Dental Records	☐ History & Physical Exams
☐ Pathology Reports	☐ Operative Reports	☐ Diagnostic Imaging Reports
☐ EKG ☐ Progress Notes	☐ Radiology Reports	☐ Consultations ☐ Outpatient Clınic Records
☐ Other_____		

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE:

SPECIFIC AUTHORIZATIONS

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment

☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment

☐ I specifically authorize the release of HIV/AIDS testing information

THE PURPOSE OF THIS RELEASE IS *(check one or more)*

☐ Continuity of care or discharge planning
☐ Billing and payment of bill
☐ At the request of the patient/patient representative
☐ Other (state reason) _____

NOTICE

Cannamed and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

☐ I understand this authorization is voluntary. Treatment, payment enrollment or eligibility benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan for 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide a third party. Under no circumstances, however, am I required to authorize the release of mental health records.

☐ I may revoke this authorization at any time, provided that I do so in writing and submit it to Cannamed 945 Concord Street Framingham, MA 01702. The revocation will take effect when Cannamed receives it, except to the extent that Cannamed or others have already relied on it.

☐ I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires _____ *(insert applicable date or event).*

If no date is indicated, this authorization will expire 12 months after the date of signing this form.

PERSONAL USE

I understand I will be charged a per page fee for copies produced for my personal use.

_____
Initial

SIGNATURE:

Date: _____

_____
(Signature of Patient or Patient's Legal Representative)

Time: _____ AM/PM

_____
Printed Name

_____
Witness or Translator

(If signed by someone other than the patient, state your legal Relationship to the patient/authority)

Mail or fax medical records/ documentation for above patient to:
Cannamed Medical Corporation
945 Concord Street
Framingham, MA 01702

Cannamed Fax:
(866)624-1191