AstranaCare
Serving members of Anthem

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION/MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Patient Address:

_____

_____

PT Phone Number:

_____

I hereby authorize_____release my health information/medical record to:

Astrana Care
14221 Euclid St Ste G., Garden Grove, CA 92843
Tel: (657) 206-8003 Fax: (657) 216-7083

[ ] Entire medical record
[ ] Medical/Surgical History
[ ] History & Physical
[ ] Physician Office Visits
[ ] Medication List
[ ] Test Results (lab,X-Ray.etc)
[ ] Record from Date _____to Date _____
[ ] Other: Specify _____

The purpose of this release is for:

[ ] Continuity of care or treatment
[ ] At the request of the patient/patient representative
[ ] Other (state reason):_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____Date:_____
Signature of Patient or Legal Representative

_____ Date: _____
Signature of Witness

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization.

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION/MEDICAL RECORD

Patient Name:_____Date of Birth:_____

Patient Address:

_____

_____

Contact Number:

I hereby authorize AMG DBA Astrana Care to release my health information/medical record to the following:

_____

Name of person or facility to receive health information/medical record (If Self, write Self.)

_____

Address

_____(___)_____

City, State, Zip Code Telephone

[ ] Entire medical record [ ] Medical/Surgical History [ ] History & Physical

[ ] Physician Office Visits [I Medication List [ ] Test Results (lab, x-Ray, etc.)

[ ] Record from Date_____to Date_____

[ ] Other: Specify _____

The purpose of this release is for:

[ ] Continuity of care or treatment

[ ] At the request of the patient/patient representative

[ ] Other (state reason):_____

This authorization is voluntary. I may revoke this authorization at any time, provided that I do so in writing and submit it to AMG, A Professional Medical Corporation DBA Astrana Care at 11236 Whittier Blvd, Whittier, CA. 90606. The revocation will take effect when Astrana Care receives it, except to the extent that Astrana Care or others have already relied on it. I understand I will be charged a fee ***$0.25 per page for*** copies produced for my personal use.

_____ Date: _____

Print Name of Patient or Legal Representative

_____

Signature of Patient or Legal Representative

Notice: This authorization for release of information expires 3 months from the date of patient's signature. Astrana Care is 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, state or federal confidentiality laws may no longer protect it.