AstranaCare

Authorization to Release Medical Information

Patient Name: _____ **Date of Birth:** _____

Phone Number: _____

I hereby authorize _____ to disclose my health records to AMG A Professional Medical Corp. for continuation of my medical care.

Please check one:
☐ Entire Record
☐ Specific Information: _____
☐ Other: _____

Please send the medical record information to:

Physician's Name: _____
Phone Number: (951) 335-8054
Address: 3975 Jackson Street, Suite 102, Riverside, CA 92503
Fax Number: (951) 281-1088

I understand this authorization may be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization or unless otherwise revoked. **This authorization will expire 90 days from the date the authorization was signed.** The facility, its employees, and physicians are hereby released from legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Patient Signature: _____ **Date:** _____

Legal Guardian (if applicable): _____ **Date:** _____