BASS Medical Group – Neurology Division
Dr. Robert Algar, Dr. Steven Schadendorf, Dr. Melissa Lehmer,
Dr. Negar Sodeifi, Dr. Caroline Perry, Dr. Kai C. Lee, Dr. Zachary deCant,
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Aurora Lee, PA, and Julianne Chaves, PA

575 Lennon Lane, Suite 152
Walnut Creek, CA 94598
Phone: (925) 602-7060 Fax: (925) 602-7070

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information regarding my medical history, illness or injury, consultations, prescriptions, treatment, diagnosis or prognosis, correspondence and/or medical records those from my other health care providers that the above-named health care provider may hold. *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization*

Patient Information:

Full Name: _____

Date of Birth: ____ / ____ / _____

Phone Number: _____

Email Address or Fax Number (optional): _____

Address: _____

Requestor Information:

Please select one of the following:

- ☐ I am the patient requesting my own medical records
- ☐ I am the patient or legal representative requesting records be sent to a third party (**facility information must be provided on the next page**)
- ☐ I am the parent/legal guardian of the patient (minor or dependent adult)
- ☐ I am the authorized legal representative with valid documentation

If not the patient, please provide:

Name of Requestor: _____

Relationship to Patient: _____

Legal Authority (e.g., POA, Guardian): _____

Documentation attached:

- ☐ Yes
- ☐ No

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Format of records:

☐ In Person
☐ Mail (from patient information section)
☐ Paper Copy
☐ Fax (from patient information section)
☐ Email (from patient information section)

Facility information **(if being released to a third party):**

Facility Name: _____

Address: _____

Phone number: _____

Fax or Email information: _____

Limitation on the type of information to disclose:

☐ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
☐ Limited (specify) _____

I also consent to the specific release of the following records:

Drugs/Alcohol/Substance Abuse _____ (initial)
Tests for Antibodies to HIV _____ (initial)
Psychiatric/Mental Health _____ (initial)
HIV Diagnosis/Treatment _____ (initial)
Genetic Information _____ (initial)

Duration :

This authorization shall be effective immediately and remain in effect until _____

Restrictions:

- Permissions for further use or disclosure of this medical information are not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
- A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.
- I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient *or legal/personal representative* | Relationship *if other than representative*

_____ _____
Witness name | Witness signature