CONSENT TO RELEASE INFORMATION

2100 Capitol Ave., Sacramento, CA 95816 (916) 442-4985, Fax (916) 442-1029

I, _____ AKA _____ DOB _____
(Name of Patient)

Address: _____

Social Security#: _____ Best Contact # _____

Hereby Authorize: C.O.R.E. MEDICAL CLINIC, INC. and _____
(Name of Person/Organization)

to mutually exchange information and medical records regarding my diagnosis and treatment. The disclosure and exchange of information and records authorized herein is required for the following purpose: _____

Such disclosure shall be limited to the following specific types of information:

Int. ☐ 1. Tx History (Dates & Progress of TX)
Int. ☐ 2. Types of Tx (MMP, MSW)
Int. ☐ 3. Medical/Lab Information & Medications (Not to include HIV info/related lab results)
Int. ☐ 4. Financial
Int. ☐ 5. Exclude UA Lab Results (Do not initial both 5 & 6)
Int. ☐ 6. Include UA Lab Results
Int. ☐ 7. Psych Diag. & Summaries
Int. ☐ 8. Other (Explain) _____

This consent is subject to revocation in writing by the undersigned at any time except to the extent that action has been taken in reliance hereon. Revocation shall be effective upon actual receipt of written revocation signed by the patient. If release is not earlier revoked, it shall, without express revocation, terminate on (1 year from signature date unless noted differently): _____(Date/ Condition)

_____	_____	_____	_____
Patient Signature	Date	Witness Signature	Date

WARNING TO AGENCY RECEIVING INFORMATION

This information has been disclosed to you from records protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. All HIV test information released must be labeled with a statement that: "This information may not be disclosed to anyone without the specific written authorization of the individual." A general authorization for the release of medical or other information is not sufficient of this purpose.

PENALTY: Not more than a $500 fine for the first offense.
Not more than a $5000 fine for subsequent offense(s).

TO REVOKE ANY PART OF THIS RELEASE REVOKES IT IN ITS ENTIRETY

Revoked By: _____ _____
Patient Signature Date