2522 Grand Canal Blvd., #13
Stockton, CA 95207
Office: (209)834-1359 Fax: (877)224-2266

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: **On Time Records Inc.**

Address: 2522 Grand Canal Blvd., #13

City: Stockton State: CA Zip Code: 95207

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ All healthcare information the provider has in his or her possession.

☐ Any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. Including records obtained in the course of any psychiatric treatments.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

This authorization may be revoked in writing at any time. My revocation will be effective upon receipt, however, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 5 YEARS AFTER IT IS SIGNED.