MOUNTAIN VIEW
MENTAL HEALTH AND PRIMARY CARE

Health Information Release Form

Please print all the information requested, then sign and date the form at the bottom of the page.

Patient Name:_____ **DOB**:_____

The following person(s) have permission for any disclosure of my personal health information and authorization to pick up any medical records pertaining to my health care.

Authorized Person Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Expiration or Termination of Authorization: This authorization will remain in effect until terminated by you, your personal representative, or another individual(s) of legal entity authorized to do so by court order or law
- Right to Revoke or Terminate: You have the right to revoke or terminate this authorization by submitting a written request at any time. This can be done in person or by mailing in a request to your office location.

Disclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

By signing below, I am indicating I have read the above information and fully acknowledge and understand the risk to my protected health information.

Patient Signature:_____ **Date**:_____

Witness Name/Title:_____

Witness Signature:_____ **Date**:_____