Holvik Family Health Center
221 E. Caldwell Ave.
Visalia, CA 93277
Ph. 559-732-4726 Fax 559-732-4747

Release Medical Records

I request and give permission for the transfer of my medical records **Date:**

Name : **DOB:**

Address: **Phone:**

From: Holvik Family Health Center
221 E. Caldwell Ave Visalia CA 93277
Ph. 559-732-4726 Fax 559-732-4747

To: _____
Doctor or Facility Name

_____
Address

_____
Phone

_____
Fax

☐ All Records

-OR-

☐ Specific Records: _____

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).

-OR-

☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental Health Records ☐ Alcohol/ Drug Abuse Treatment

☐ Communicable Diseases ☐ Other: _____

Signature: _____ Date: _____

This authorization is effective for up to one year after date signed by patient. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation.h