Santa Cruz
Direct Primary Care

Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____
Date of Request: _____

Record from Provider: _____
Address of Provider: _____
_____

Records Being Requested:

___All Clinical Records ☐All Dates ☐Specific Date(s): _____

___Emergency Department Records
___Discharge Summary
___History and Physical
___Physician Notes
___Health Maintenance Records
___Imaging Results
___Specific Information as follows: _____

___Operative Reports
___Pathology Reports
___Laboratories/Test Results
___Medication Lists

___Please DO NOT release the following records:
_____Behavioral Health Records/Psychiatric Records
_____HIV Status
_____Drug or Alcohol Treatment Programs
_____Other_____

Please send the above information to:

Santa Cruz Direct Primary Care
Jeannine Rodems, MD
Adam Yarme, MD
Fax: (831) 708-1390

9000 Soquel Avenue, Suite 100
Santa Cruz, CA 95062
Phone: (831) 708-1400

Signature of Patient/Legal Representative: _____
Person Requesting Records (if not the patient): _____
Relationship: _____

Home Phone: _____ Daytime Phone: _____
Expiration of Authorization, if indicated (date)_____

Your rights with respect to this Authorization: I am aware that I have the right to inspect and receive a copy of the health information I have authorized by this agreement. I understand that I may be charged a fee for record copies. I understand that I do not need to sign this authorization in order to receive treatment. I also am aware that I may revoke this authorization in writing, however, I understand that my revocation will not be effective as the to uses and disclosures already made in reliance upon the authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure.

Date Faxed:
Date Record Received:
MD for review: