Authorization for Release of Medical Information
(must be legible)
Please contact Heidi Jimenez at 530.581.8864 x 9 with any questions.
Return completed request via fax 530.587.6730 or email to hjimenez@ttmg.net

Patient *Legal* Name: ____

Date of Birth: ____________________ **Phone #:** _______________________

I Authorize Truckee Tahoe Medical Group to: (Check one)

☐ **Release records to:** ☐ **Obtain Records from:**

Authorized Recipient or Facility: ____________________________________

Address: ____

City: ____________________________ **State:** _____ **Zip:** ______________

Phone Number: ___________________ **Fax Number:** ____________________

Health Information Requested:

☐ Billing Records
☐ X-ray Image ($15.00 charge for CD copy)
☐ Radiology Report
☐ Immunization History
☐ Lab Results
☐ Other____________________________________
☐ **Date(s) of service*:*** _________________________
☐ **ALL Records for the past 6 years**

Method of Delivery:

☐ Pick Up at Business Office: 10956 Donner Pass Rd Ste 360 Truckee, CA 96161 (M-F)
☐ Mail via USPS
☐ E-mail (not secured): ___________________________________

Please Complete both Sides

I understand that:

- This Authorization will become effective immediately and will expire on ______________ [Date]. If no date is specified, this authorization will expire one (1) year from the signature date.

- I may revoke this Authorization at any time, in a written revocation sent to the Custodian of Records. However, I understand that my health information might have already been released.

- Information released by this Authorization might be re-disclosed by the recipient and might not be protected by state and federal privacy laws. I agree to release Truckee Tahoe Medical Group from liability for release and disclosure of the released information.

- I am aware Truckee Tahoe Medical Group will only release records ordered by Truckee Tahoe Medical Group and I will need to obtain outside records on my own.

Patient/Representative Signature: ______________________________

Print Name (If not patient): _____________________________________

Relationship to patient: ____

Date: _____________________

****Please allow 1-2 weeks for processing**