Truckee Tahoe Medical Group
Return your completed request via email
scheduling@ttmg.net or fax 530.587.6730

Mailing Address: 10956 Donner Pass Rd #110
Truckee, CA 96161
530.581.TTMG

Authorization for Release of Medical Information – must be legible

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Patient's phone #: ( ) _____ **Date of Request:** _____

I authorize TTMG **to: (choose one)**

❒ **release my medical records to**:
❒ **obtain my health records from:**
❒ **discuss my health/billing information with:**

_____
Name of Person/Provider/or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #

How would you like to receive your records?

❒ **MyChart Portal** – must provide email address
(secure portal for all electronic records)

_____
Email Address (PRINT CLEARLY)

❒ **Email**
(by choosing email you understand that this method of delivery is not secure/encrypted)

_____
Email Address (PRINT CLEARLY)

❒ **Fax**

_____
Fax # (include area code)

❒ **Paper via USPS**

see below for fee information

PURPOSE FOR THIS REQUEST: (Check **one**.) ❒ Healthcare provider request ❒ Personal

TYPE OF RECORDS REQUESTED: (Check **one**.)
❒ Past 12 months ❒ Past 5 years ❒ Specific Dates _____
Specify date(s) of treatment

OR

❒ Specific information (Select one or more, as applicable)
❒ Procedure report _____ ❒ Immunization history ❒ Laboratory test results_____
❒ X-ray reports_____ ❒ Other _____

AUTHORIZATION VALID FOR: (Check one.)
❒ This request only.

I understand that:

- My records may be copied by an outside vendor and will be sent to me on a **disk**.
- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- **There may be a $20 processing fee to copy your paper records and a $15 processing fee + shipping to release x-ray disks to another provider/facility.**

Print Patient Name: _____

Signature of Patient: _____ Date _____ v2016