Consent for Release of Medical Records

As required by the Health Information Portability and Accountability of 1996 (HIPPA), this practice may not disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the transfer of health information described below. Please review and complete this form carefully. It may be invalid if not fully completed.

Patient: _____ DOB: _____
Address: _____

Previous physician's information

Release From:
_____
Address:_____
_____
Ph: _____
Fax:_____

Release To:
Dr. Yovana Bruno, MD
Address: 3553 Camino Mira Costa Suite D
San Clemente, CA 92672
Ph: (949) 200-7737
Fax: (949) 336-1949

By initialing the spaces below, I specifically authorize the use of disclosure if the following health information and/or records:

_____ Entire medical record (all information) and/or records
_____ Office chart notes
_____ X-ray reports
_____ Immunization records
_____ Laboratory reports
_____ Billing statements
_____ Other:_____
_____ Mental Health/ Psychotherapy notes

_____ _____
Signature of Patient or Patient's Legal Guardian Date

_____ _____
Print Name of Legal Guardian (if applicable) Relationship to Patient