

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM/TO
SAN BERNARDINO COUNTY CENTER FOR EMPLOYEE HEALTH AND WELLNESS**

EXPLANATION:

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, "Civil Code section 56 et.seq."

AUTHORIZATION:

I hereby authorize _____ ()
Name of physician, hospital, or health care provider Telephone number

address _____ City _____ State _____ Zip _____

to furnish to The County of San Bernardino, Center for Employee Health and Wellness (909) 580-1701
Name of physician, hospital, or health care provider Telephone number

400 North Pepper Avenue Colton CA 92324
address _____ City _____ State _____ Zip _____

medical records information pertaining to medical history, physical or mental condition, psychiatric illness and treatment, and treatment for substance and/or alcohol abuse.

This authorization is limited to the following medical records and type of information:

_____ Complete Medical Record _____ Records of Diagnostic Test(s)
_____ Other [specify] _____

RESTRICTIONS:

I understand that the San Bernardino County Center for Employee Health and Wellness may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

The medical information will be used for the following purpose: _____

DURATION:

This authorization shall become effective immediately and shall remain in effect until [date] _____, unless earlier revoked in writing.

ADDITIONAL COPY:

I further understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received _____ Yes _____ No Initial _____

SIGNATURE:

Signature: _____
(client/representative/spouse/responsible party)

Date: _____ Time: _____ (A.M./P.M.)

If signed by other than client, indicate relationship: _____

Witness: _____

CLIENT IDENTIFYING INFORMATION

Name: _____	San Bernardino County Center for Employee Health and Wellness	File Provided as Requested
DOB: _____	400 N. Pepper Ave	To: _____
SSN/EE ID: _____	Colton, CA 92324	Route: _____
	Phone (909) 580-1701 Fax (909) 580-1359	Date: _____
Approval to process request - Date _____	Initials _____	Unable to Locate: _____
		Initials _____