MEDICAL RELEASE FORM

If you need this form translated in your language or if you have any questions, please call CalOptima's Customer Service Department at (888) 587-8088.

AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN MÉDICA

Si necesita esta carta traducida en su idioma o si usted tiene preguntas, favor de llamar al Departamento de Servicios Para Miembros de CalOptima al (888) 587-8088.

ĐƠN CHO PHÉP CHIA XẺ HỒ SƠ BỆNH LÝ

Nếu quí vị cần chuyển dịch đơn này qua tiếng Việt hoặc có gì thắc mắc, xin gọi Văn Phòng Dịch Vụ của CalOptima ở số (888) 587-8088.

Did you recently change your doctor? In order to provide you with the best care, your new doctor may need your medical records from your last doctor. However, because they are **your** medical records, you are the only person who can allow them to be moved. **If you are changing doctors, please fill out and return this form to your new doctor's office. Call your doctor's office if you have any questions about this form, or if you need help filling it out.**

Dear: ____

(Name of your previous doctor or health care provider)

I allow you to give to ____, at

(Name of your new doctor or health care provider)

____, the following information:

(Address and phone number of your new doctor or health care provider)

☐ All health information and records about my medical history, mental or physical health, and treatment that I received from ___ / ___ / ___ to today's date.

or

☐ Only these records or types of health information (including any dates):

____

____

____

I specifically allow you to give the following information (check as appropriate):

☐ Mental health treatment information

☐ HIV test results

☐ Alcohol or drug treatment information

The reason I am requesting this information is because I have changed my doctor. I understand that:

- This letter can only be used from now until one hundred eighty (180) days after the day I sign it.
- This letter cannot be used to move my medical records again unless I sign another letter or unless the law requires or allows my medical records to be moved.
- I may receive copies of this letter from my doctor after I sign it.
- I may take back this letter at any time.
- I have a right to not sign this letter if I don't want my medical records moved.
- My doctor can't change any treatments or fees because I sign or don't sign this letter.

Member Name (please print)

Member's Signature

Date

If the member is a minor or has an authorized representative:

Name of parent or authorized representative (please print)

Relationship to member

Signature of parent or authorized representative

Date

IF YOU ARE CHANGING DOCTORS, PLEASE FILL OUT AND RETURN THIS FORM TO YOUR NEW DOCTOR'S OFFICE.