Please send request to:
Medical Records – Release of Information
1300 Crane Street, Menlo Park, CA 94025
Phone: (650) 498-6166; Fax (650)324-9447

Office Use Only:
MRN: _____

MENLO MEDICAL CLINIC
Affiliated with Stanford Hospital & Clinics

Authorization – Disclosure of Health Information

This authorization is for the use of disclosure of health information pertaining to:

Patient's Name: Last:_____ First: _____MI ____

DOB: _____ Phone# _____ Cell#_____ Fax# _____

I hereby authorize:

_____ _____
Name of Person or Organization Releasing Information *Address* *City* *State* *Zip*

To disclose health information to:

_____
Name of Person or Organization Receiving Information *Address* *City* *State* *Zip*

This authorization applies to the following information:

❒ Medical Records (**Specify** document(s)/date(s)): _____
_____ or ❒ All records _____ to _____
Charges/Preference: Patient Access ❒ CD- $25.00,
❒ Hard Copy/paper record over 20 pages $0.25, ❒ Continued Care – No Charge
❒ I will pick up-3rd Floor-Medical Records Department; or ❒ Mail to the above address
❒ Radiology Film – ❒ I will pick up-1st Floor Radiology or ❒ Mail to the above address
Any questions, call 650-498-6522 (**Specify** Type of films/date(s): _____
❒ Billing Records – If requesting MMC Billing Records only, please mail this request directly to the Billing Department at 855 Oak Grove, Menlo Park 94025. Any questions, call 650-498-6133. (**Specify** date(s) of service):_____

Specific authorization is required to disclose information regarding the following:

(Check box and sign to specify information is to be disclosed):
❒ Psychiatric/Mental Health _____ ❒ HIV Lab Test Results _____
❒ Drug/Alcohol Abuse _____ ❒ Genetic/Fertility _____

The recipient may use the health information authorized on this form for the following purpose. (Specify):

- I may refuse to sign and my refusal will not affect my ability to obtain treatment.
- The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless the use or disclosure is specifically permitted by law. Date: _____ I authorize, _____, ❒ to pick up my protected health
- Information, ❒ have access to my PHI. Picture ID required. Signature: _____
- This authorization shall become effective immediately and shall remain in effect for six months from date of signature.
- I reserve the right to withdraw or revoke this authorization, in writing, at any time, except to the extent that MMC has already disclosed the information.
- I understand that I have a right to receive a copy of this authorization.

Signature: _____ Date: _____
If signed by other than the patient, indicate relationship: _____