

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



Menlo Medical Clinic
Affiliated with Stanford Hospital & Clinics

Authorization – Disclosure of Health Information

Office Use Only:
MRN: _____

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 _____
 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): _____

A 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: _____

If leaving MMC, please note the reason: Moving Ins Change Other _____

Charges/Preference: Patient Access: CD - \$25; Hard Copy/paper records 10¢ per page (add'l charge); Continued Care – No Charge