

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please type or print legibly in ink. Please note that if you do not execute this release, the Telephone Medical Advice Services Bureau may not be able to investigate or forward the complaint.

Patient's Name: _____ Date of birth*: _____

I, the undersigned, have authority to authorize and hereby authorize

Print name of telephone medical advice service

Address City State Zip Code

Telephone number (including area code)

Registration number

Medical provider's name

to disclose the above named patient's medical information pertaining to telephone medical advice services provided to the patient to the Telephone Medical Advice Services Bureau of the Department of Consumer Affairs (Bureau). I understand that the Bureau may release these records to another government agency.

Medical information obtained pursuant to this authorization will be used for investigation into, and possibly legal proceedings (administrative or otherwise) following, any violations of California laws and/or regulations.

I understand that I have a right to receive a copy of this authorization.

This authorization shall expire three (3) years from the date of signature below.

Patient's or legal representative's signature

Date

If a legal representative is authorizing this release, please complete the following information:

Printed name of legal representative

Relationship to Patient

*Date of birth is needed to positively establish the identity of the complainant.