# Consent and Authorization to Release Medical Records

Pursuant to Federal guidelines concerning my right to confidentiality,

I_______________________________ authorize
Print name

Physician: Dawn Terashita
Facility Name: Passport Health
Phone: 619-293-3963

to release my records or information concerning my medical records to

__________________________________________________

Address:__________________________________________________

I understand that I may revoke this consent to release information at any time.

However, I also understand that any release which has been made prior to my revocation

is my responsibility, and any release which has been made after my revocation and which

in reliance upon this authorization shall constitute a breech of my

right to confidentiality.

________________________________
Print Name

________________________________
Patient's signature

________________________________
Date

Passport Health
2525 Camino del Rio South* Suite 325* San Diego, California 92108
Phone: 619-293-3963* Fax: 619-293-3936