OC PHARMACY™
Custom Compounding Specialists

MEDICAL RECORD RELEASE FORM

AUTHORIZATION FOR USE OR DISCOLOSURE OF HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

Authorization for: ☐Copies of Medical Record ☐ Inspect or Review Medical Record ☐ Release of Medications to 3rd Party

<table>
<tr><td>Patient Information</td><td colspan="3">Patient Name:_____
Last Name First Name

Date of Birth:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____</td></tr>
<tr><td>Release To</td><td>I Authorize OC Pharmacy™ to Release Medical Records/Medications to:
Person/Organization:_____

Address:_____

City/State/Zip:_____

Phone:_____ Fax:_____</td><td>Purpose</td><td>For the Following:
__Continuing Care
__Insurance
__Legal
__Personal Use
__Other:_____
_____
_____</td></tr>
<tr><td>Information to Release</td><td>Treatment Date or Date Range_____

__Drug History Report

__Insurance Pay Amt

__ Written Prescription

__Payment History (A/R Accounts Only)

__Filled Medication</td><td>Fees</td><td>Based on California Evidence Code Section 1560-1567 Fees May be Charged for medical record copies.*</td></tr>
<tr><td>Delivery Instructions</td><td colspan="3">☐Mail records directly to person or organization specified
☐Call Requestor when records are ready for pick up
I authorize _____ to pick up my medical record copies
Relationship to patient:_____
☐Other:_____
_____
_____</td></tr>
</table>

TURN OVER AND COMPLETE NEXT PAGE

31654 Rancho Viejo Road, Unit N, San Juan Capistrano, CA 92675 Phone: (800) 429-5102 Fax: (949) 429-5328
www.ocpharmacy.net

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Notice of Rights	**I understand that:** 1. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment. 2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. **3.** I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to **OC Pharmacy, 31654 Rancho Viejo Rd. Suite N, San Juan Capistrano, CA 92675** 4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation. 5. I have a right to receive a copy of this authorization. 6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPM). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically requested or permited by law. 7. If this ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.
Expiration	Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified:_____
Signature	Signature_____(Patient or Legal Representative) Date_____ Legal Representative Relationship:_____

*Copies incur a cost of $0.60 per page. For mailings, there is an additional cost of $8.00 regardless of number of pages; however, shipping cost may vary with weight.

Notarize here:

State of California

County of _____

Subscribed and sworn to (or affirmed) before me on this ___ day of _____, 20____ by

(1)_____
Name of Signer

Proven to me on the basis of satisfactory evidence to be the person who appeared before me (.) (,)

(and

(2)_____
Name of Signer

Proved to me on the basis of satisfactory evidence to be the person who appeared before me.)

Place Notary Seal Above

Signature_____
Signature of Notary Public

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