



Sovereign Health of California (SHoCA)
209 Avenida Fabricante, Suite #100, San Clemente, California 92672
Tel. 949.369.1300 Fax 949.498.2619

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ hereby authorize and request
(Client's Name)

_____ at _____
(Practitioner or School) (Address)

to release and obtain all pertinent confidential professional information pertaining to me (or my child) to

PURPOSE OF RELEASE

At the request of the patient/patient representative
Other (state reason) _____

NOTICE

Sovereign Health of California and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

MY RIGHTS

I understand that I have a right to receive a copy of this authorization. I understand that I have the right to revoke this authorization, in writing and submit to Sovereign Health of California, 209 Avenida Fabricante, Suite 100, San Clemente, California 92672. The revocation will take effect upon receipt except to the extent of prior use granted by the consent.

I understand that I have the right to refuse consent and Sovereign Health of California shall not condition my treatment with this refusal.

EXPIRATION OF AUTHORIZATION

This authorization shall remain valid for:
1-year from date indicated below
Terminate on date: _____

SIGNATURE

(Signature of patient or patient's Legal Representative)

Date: _____

Printed Name

(if signed by someone other than the patient, state your relationship to the patient)

A Xerox and/or facsimile copy of this authorization shall be valid as the signed original on file.