Holvik Family Health Center
221 E. Caldwell Ave.
Visalia, CA 93277
Ph. 559-732-4726 Fax 559-732-4747

Request Medical Records

I request and give permission for the transfer of my medical records **Date:**

Name :
Address:
DOB:
Phone:

To: Holvik Family Health Center
221 E. Caldwell Ave Visalia CA 93277
Ph. 559-732-4726 Fax 559-732-4747

From: ______________________________
Doctor or Facility Name

____
Address

____
Phone

____
Fax

☐ All Records

-OR-

☐ Specific Records: ______________________________

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).
-OR-

☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental Health Records ☐ Alcohol/ Drug Abuse Treatment

☐ Communicable Diseases ☐ Other: ______________________

Signature: ______________________ Date: ______________________

This authorization is effective for up to one year after date signed by patient. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation.