SAN BERNARDINO COUNTY | Human Resources
Center for Employee Health and Wellness

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM/TO SAN BERNARDINO COUNTY CENTER FOR EMPLOYEE HEALTH AND WELLNESS

EXPLANATION: This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981,"Civil Code section 56 et. Seq."

AUTHORIZATION: **The County of San Bernardino, Center for Employee Health & Wellness** **(909) 580-1701**

I hereby authorize – Name of Physician, Hospital, or Health Care Provider — Telephone Number

400 N. Pepper Ave. 2nd Floor	Colton	CA	92324
Address	City	State	Zip Code

To furnish to – Name of Physician, Hospital, or Health Care Provider — Telephone Number

Address — City — State — Zip Code

Medical records information pertaining to medical history, physical or mental condition, psychiatric illness and treatment, treatment for substance and/or alcohol abuse.

_____ Complete Medical Record _____ Records of Diagnostic Test(s)

_____ Other (Specify) _____

RESTRICTIONS: I UNDERSTAND THAT The San Bernardino County Center for Employee Health and Wellness may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

The medical information will be used for the following purpose: _____

DURATION: This authorization shall become effective immediately and shall remain in effect until:
(Date) _____ /_____/_____ unless earlier revoked in writing.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request.
Copy requested and received. Yes _____ No _____ Initial _____

SIGNATURE: _____ Date/Time: _____
(Client/Representative/Spouse/Responsible Party)
**If signed by other than client, indicate relationship: _____

WITNESS: _____ Date/Time: _____

Client Identifying Information	**San Bernardino County**	**File Provided as Requested**
Name:	**Center for Employee Health & Wellness**	**To:**
D.O.B.	**400 N. Pepper Ave. 2nd Floor**	**Route:**
SSN/EE ID:	**Colton, CA 92324**	**Date: / /**
	Phone: (909) 580-1701	**Unable to Locate:**
	Fax: (909) 580-1359	**Initials:**
		Provider:

Approval to process request: **Date: / /** **Initials:** _____