

Release of Medical Records

Matthew May, M.D.
1220 University Drive, Ste. 201
Menlo Park, CA 94025

Patient Identification:

Patient Name: _____ Sex: _____ Date of Birth: _____

Address: _____ Telephone Number: _____

If requested by Personal/Legal Representative (Name & Relationship): _____

Request for Inspection and/or Copying of Your Health Information

You have a right to inspect and obtain a copy of your health information for as long as we maintain the information in our records, with certain limited exceptions. To submit a request, please fill in the following information:

Indicate preference:

- I will inspect the records in the office
- I will pick up the copies requested
- Please mail the copies I requested to the address above

Indicate preference:

- Please release my entire medical record
- Please summarize my medical record

Under certain limited circumstances, your request to inspect and/or copy health information may be denied. If access is denied, you may request that the denial be reviewed. Instructions for the review process will be included with any denial.

There may be fees associated with copying and mailing records.

Information to be Disclosed:

I hereby authorize disclosure of the following records:

<input type="checkbox"/>	Consult Report	<input type="checkbox"/>	History & Physical Evaluation
<input type="checkbox"/>	Neuropsychiatric Testing	<input type="checkbox"/>	Medication History
<input type="checkbox"/>	Lab Reports	<input type="checkbox"/>	Progress Reports
<input type="checkbox"/>	Phone Conversation	<input type="checkbox"/>	Ongoing Treatment Approach
<input type="checkbox"/>	Other (treatment recommendations)	<input type="checkbox"/>	Other

To access or disclose any of the following restricted information, initial the appropriate line(s):

___ HIV Test Result ___x___ Alcohol/Drug Abuse ___x___ Psychiatric/Mental Health

This authorization shall become effective immediately and shall expire 6 months from this date unless indicated otherwise or revoked earlier in writing. I understand that this same information cannot be further released without my written consent and that no further authorization is made than is specifically indicated herein.

I understand that I may refuse to sign this authorization and that Dr. May will not condition my treatment upon whether I sign this authorization. I understand that if I have authorized the disclosure of information to someone who is not legally required to keep it confidential, the recipient may re-disclose it, and it may no longer be protected.

I further understand that I have a right to receive a copy of this authorization form upon my request.

Your Signature: _____

If Other than Patient, Relationship to Patient: _____

Date of Request: _____