BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834
P (916) 928-8390 |F (916) 928-8392 | www.ombc.ca.gov

SUBJECT (PHYSICIAN) AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

CHECK ALL RECORD TYPES THAT APPLY

- ☐ Medical Records
- ☐ HIV/AIDS
- ☐ Psychiatric
- ☐ Diagnostic Images
- ☐ Alcohol/Drug Abuse

PATIENT INFORMATION

Patient Name

Date of Birth

Medical Record Number (*If known*) or SSN

Date of Death (*If applicable*)

Subject (Physician) Authorization for Release of Patient Health Information

Patient Name:	

I, the undersigned, hereby authorize the following provider to release, disclose, and discuss information pursuant to my authorization below:

Osteopathic Physician:			
Facility Name:			
Facility Address:			
City:		State:	Zip Code:
Phone Number:	Treatment Date(s):		

By my signature below, I hereby authorize the provider listed above to disclose medical records in the course of my diagnosis and treatment to the State of California, Department of Consumer Affairs ("DCA"), Osteopathic Medical Board of California ("OMBC"), a state regulatory agency, and to discuss that diagnosis and treatment in an investigative interview and any subsequent proceedings with DCA's Division of Investigation ("DOI") a state law enforcement agency. DOI is comprised of peace officers who conduct investigations on behalf of licensing and regulatory boards who are each a "health oversight agency." This disclosure of records and authorization to discuss my care, as authorized herein, is required for official use including investigation and possible administrative and/or criminal proceedings regarding any violations of State or Federal law. This authorization shall remain valid for three years from the date of signature. A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the OMBC at the above address. My written revocation will be effective upon receipt by the OMBC but will not be effective to the extent that such persons have acted in reliance upon this authorization. I understand that the recipient of my information is not a health plan or health care provider, and the released information may no longer be protected by federal privacy regulations. I am signing this authorization voluntarily and understand that treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

Patient Signature _____ Date _____

- OR -

Legal Representative Name _____ Relationship to Patient _____

Legal Representative Signature _____ Date _____

NOTE: Failure by a health care provider, or health care facility with electronic medical records to provide the requested certified records within 15 days of receipt of this request and authorization (30 days for a health care facility without electronic records), may constitute violations of Sections 2225 and/or 2225.5 of the Medical Practice Act and may result in further action.