## Community Health Care Center

Dr. Martin Zapata Internal Medicine

9818 Paramount Blvd. Suite C Downey, CA 90240

Phone 562-806-1214 Fax 562-806-1218

	Medical Record	d Release Form	
Written authorization f	or use and/or disclosure of medica	l information release records an	d information regarding:
Date:			
Patient Name:		DOB:	
Release records to:	Community Heal	th Care Center	
	Name of Receiving Party		
	9818 Paramoun	t Blvd. Suite C	
	Address		
	Downey, C	A 90240	
	City, State, Zip Code		
(562) 806-1	214	(562) 806-1218	
Telephor		Fax	
A. All health inforeceived: OR  Only  B. I specifically a  Men  HIV t	th information released pursuant to remation pertaining to my medical the following records or type of he authorize release of the following in tal Health treatment information test results hol/drug treatment information on is required to authorize the discontinuous test results the discontinuous required to authorize the discontinuous test required test required to authorize the discontinuous test required test require	history, mental or physical cond ealth information (including any nformation (check as appropriate	ition and treatment date):  e)
I have received a copy Print Name/Signatur	of this authorization:(ini	tial) A copy of this authorization	is valid as an original.
Treatment, payment, en authorization.  Duration: This authorizating signature if no date enter Revocation: This Authoriof information by the distance of the second	rollment or eligibility benefits will not tion shall become immediately and sha	all remain effect until ution by the undersigned at time bet be effective upon receipt, but will no	or for one year from date of

Redisclosure: I understand the requester may not lawfully further use or disclose the health information unless another

authorization is obtained from me or unless disclosure is specifically required or permitted by law.