PAB PHYSICIAN ASSISTANT BOARD

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DEPARTMENT OF CONSUMER AFFAIRS • PHYSICIAN ASSISTANT BOARD

2005 Evergreen Street, Suite 2250, Sacramento, CA 95815

P (916) 561-8780 | F (916) 263-2671 | paboard@dca.ca.gov | www.pab.ca.gov

Physician/Provider/Facility Authorization for Release of Information

CHECK ALL RECORD TYPES THAT APPLY

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

PATIENT INFORMATION

Patient Name
Date of Birth
Date of Death (If applicable)
Medical Record Number (If known)
Control Number

I, the undersigned hereby authorize:

Physician/Provider/Facility			
Street Address			
City		State	Zip Code
Phone Number	Treatment Date(s)		

Physician/Provider/Facility			
Street Address			
City		State	Zip Code
Phone Number	Treatment Date(s)		

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Physician/Provider/Facility			
Street Address			
City		State	Zip Code
Phone Number	Treatment Date(s)		

to disclose medical records in the course of my diagnosis and treatment to the **Physician Assistant Board of California, Enforcement Program,** a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative and/or criminal proceedings regarding any violations of the laws of the State of California. 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 the right to receive a copy of this authorization if requested by me. I understand that I have a right to revoke this authorization by sending written notification to the Physician Assistant Board at the above address. My written revocation will be effective upon receipt by the Physician Assistant Board 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 healthcare 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 physician or healthcare provider to provide the requested records within 15 days, or a healthcare facility within 30 days, of receipt of this request and authorization may constitute a violation of Section 2225.5 of the Medical Practice Act and may result in further action by the Board.

2005 Evergreen St., Suite 2250, Sacramento, CA 95815-3893 ● (916) 561-8780 ● FAX: (916) 263-2671 ● paboard@dca.ca.gov ● www.pab.ca.gov