Turnure Medical Group, Inc.
Authorization for Release of Medical Records

To:

_____

Previous Physician/clinic Phone Number/Fax

_____

Street Address

_____

City State Zip

NOTICE:

Physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidential law may no longer protect it.

REDISCLOSURE:

I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

YOUR RIGHTS:

This authorization to release health information is voluntary. This authorization shall become effective immediately and shall remain in effect one-year from the date of signature unless a different date is specified here _____. Treatment, payment, enrollment of eligibility from benefits may not be conditioned on signing this authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party. This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Turnure Medical Group, Inc. The revocation will take effect the date we receive it. You are entitled to receive a copy of the authorization if you request it.

By signing below I hereby authorize the release of my medical records to the following physicians:

Turnure Medical Group, Inc.
6805 Five Star Blvd., Suite 100
Rocklin, California 95677
Telephone: (916) 624-3500
Facsimile: (916) 624-3351

- **Raymond E. Turnure III, M.D.**
- **Brön C. Hedman, M.D.**
- **Richard Lichti, M.D.**
- **Kimberly Perkins, M.D.**
- **David Couillard, M.D. – Urologist**

Specify records: ____Medical Information _____

____Psychiatric Information

_____ _____
Signature Date

____Drug/Alcohol Information

_____ _____
Signature Date

____Results of an HIV Blood Test

_____ _____
Signature Date

____Other Health Information (specify below)

____ Urology Only

Specify the records to be disclosed:

_____

_____

_____

Print Name Birthdate

_____

_____
Signature (Patient/Parent/Guardian) Date

If signed by other than patient, indicate relationship: _____

Release of Medical Information to Family Members

Turnure Medical Group, Inc.

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Raymond Turnure, M.D. Richard Lichti, M.D. Bron Hedman, M.D.
Kimberly Perkins, M.D. David Couillard, M.D.

I, authorize Turnure Medical Group to discuss and release all medical information to family members named below. This includes medical records, x-rays, history, findings and prognosis pertaining to the medical condition, services rendered, or treatment given to me. This authorization complies with the Confidentiality of Medical Information Act, Section 56 ET SEQ of the California Civil Code.

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Patient Signature Date