This authorization to release information is being requested of you to comply with the terms of Confidentiality of Information Act of 1980, Section 56, et seq. of California Civil Code, Federal Regulation 42 CFR, Section 2, and Welfare and Institutions Code 5328.

The undersigned hereby authorizes _____, or their agent, Kopy Kat, to inspect, photocopy and receive all information pertaining to me.

Patient: _____
Last **First** **Middle**

Date of Birth: _____ **Social Security #**: _____

This is to request and authorize:_____

(Check the information below for release)

_____ **All Medical Records**	_____ **X-Ray/MRI Films**
_____ **Emergency Room Records**	_____ **Scholastic Records**
_____ **Billing Records**	_____ **Employment Records**
_____ **Psychiatric, Drug & Alcohol**	_____ **Insurance Claim File**
__ __ All of the above	**Records**

Other Information: _____

I agree this authorization shall be **valid for one (1) year** from the date below.
I agree that a photographic **copy of this authorization shall be as valid as the original**.
I realize that I am entitled to a copy of this authorization.

Date: _____ Signature:_____