



California State Board of Pharmacy
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Business, Consumer Services and Housing Agency
 Department of Consumer Affairs
 Gavin Newsom, Governor

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize
 (Complainant/Patient) (Date of birth)*

 (Person or entity and telephone number from which information may be obtained)

to disclose all records and information and answer any questions pertaining to the diagnosis and course of my treatment to the Board of Pharmacy (Board) and its representatives, including, but not limited to, investigators and legal staff, upon their request. I further agree to allow the Board and its representatives to process and possibly file an administrative action based upon my complaint against:

 (Person/business being complained about – include license/registration number if known)

I understand that this information will be maintained in confidence and will be used solely in conjunction with any investigation and possible legal proceeding regarding any violations of state and/or federal laws and regulations. I further agree that the Board and its representatives may release any and all of my records and treatment information to any other government agency which requests, or has been provided with, such information as part of an investigation into other possible violations of state and/or federal laws and regulations. This authorization shall be valid until completion of an investigation and prosecution, including any investigation and proceeding by another governmental agency that has requested, or been provided with, your records and information.

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.

 Complainant/Patient Signature Date

OR

 Complainant's/Patient's Representative and Relationship Date

*Date of birth is needed to positively establish the identity of the patient