Phone: (909) 483-7800 or (909) 982-5111
Fax: (909) 483-0760

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: ____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: ____
Name

____
Address

______________________ __________ __________
City State Zip Code

The medical information/records will be used for the following purpose: ______________________

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: ______________________

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse________(initial) HIV Diagnosis/Treatment _______(initial)

Psychiatric/Mental Health ________(initial) Genetic Information _______(initial)

Tests for Antibodies to HIV ________(initial)

DURATION

This authorization shall be effective immediately and remain in effect until______________________
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

______________________ __________ ______________________
Signature of patient *or legal/personal representative* Relationship *if other than patient*

______________________ ______________________
Patient's Name (PRINT) Date

______________________ ______________________
Patient's Social Security Number Patient's Date of Birth

______________________ ______________________
Witness name Witness signature