

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 on _____ (Patient's Name)
_____ (Patient's DOB) 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:	Troy Lamar MD	(626)445-0600 ph#	(626)574-8654 fx#
	Name		
	51 N. Fifth Avenue, Ste. 202		
	Address		
	Arcadia	CA	91006
	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)
Psychiatric/Mental Health	_____ (initial)
Tests for Antibodies to HIV	_____ (initial)
HIV Diagnosis/Treatment	_____ (initial)
Genetic Information	_____ (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 patient*

Self
Relationship *if other than*

Patient's Name (PRINT)

Date

N/A

Patient's Social Security Number

Patient's Date of Birth

Witness name

Witness signature