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 authorizations.*

Authorization

I hereby authorize:

Physician/Office name:____

Phone Number:_____________________________

To release information on ________________________________(Patient's name) ______________(Date of birth) 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: Pacific ENT Medical Group, Inc. Phone: (858) 755-9343

6010 Hidden Valley Rd. Suite 201 Fax: (858) 792-1790

Carlsbad Ca. 92011

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)
Test for antibodies to HIV ____(Initial)
HIV diagnosis/treatment ____(Initial)
Genetic information ____(Initial)

Duration

This authorization shall be effective immediately and remain in effect until _________.

Restrictions

Permission 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 or facsimile of this authorization shall be considered as effective and valid as the original.

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

___________________________________	___________________________________
Signature of patient or legal representative	Relationship *if other than patient*
___________________________________	___________________________________
Patients name	Date
___________________________________	___________________________________
Witness name	Witness signature