IRVINE
INTERNAL MEDICAL
GROUP

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

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

I hereby authorize:

_____
Name

_____
Address

_____
City / State / Zip Code

_____ _____
Phone Fax

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: **Irvine Internal Medical Group, Inc.**
22 Odyssey, Suite 140
Irvine, CA 92618

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

_____

This authorization is:
{____} Unlimited (all records including Substance Abuse, Mental Health, HIV Diagnosis / Treatment)
{____} Limited to the following medical information: _____

_____

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

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 right to receive a copy of this authorization.

_____ _____
Signature of Patient, Guardian / Legal Representative Relationship (if other than Patient)

_____ _____
Patient's Name (PRINT) Date of Request

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

_____ _____
Witness Date Records Sent