

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 treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

I hereby authorize: _____
Physician / Healthcare Facility

Address / City / State / Zip Code

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.
Name
4870 Barranca Parkway, Suite 330
Address
Irvine, CA 92604-4737
City / State / Zip Code

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

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