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: Dr. Angela Allevato MD Phone- (714)639-0662 Fax- (714) 639-0660
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 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 _____(initials) Tests for Antibodies to HIV_____
Psychiatric/Mental Health _____(initials) HIV Diagnosis/Treatment _____

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 require 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) Patient's D.O.B Date of request

_____ _____
Witness Name Witness Signature