SIERRA MADRE COMMUNITY MEDICAL GROUP
147 W. Sierra Madre Boulevard, Sierra Madre, CA 91024

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION PROTECTED HEALTH 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.*

AUTHROIZATION

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: _____
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 and Treatment)

[ ] Limited to the following medical information:

_____

_____

_____

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DO NOT RELEASE ANY OF THE FOLLOWING: (check all that apply)

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 of patient* | Relationship to patient

_____ _____

Patient's Name (PRINT) | Date

_____ _____

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

_____ _____

Witness Name | Witness Signature

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