AUTHORIZATION TO RELEASE MEDICAL RECORDS

REQUESTING PARTY: Today's Date_____

Printed Legal Name _____ Date of Birth_____

I, the undersigned, hereby authorize:

Name of Agency or doctor _____

Address_____

City, State, Zip_____

Phone_____

Fax_____

TO RELEASE MY INFORMATION TO:

Dr. _____
1831 Orange Ave., #A
Costa Mesa, CA 92627

Tel: (949) 574-4978
Fax: (949) 574-9854

Information to be released:

_____ALL MEDICAL RECORDS

_____OTHER_____

Sign next to "Yes" or "No" for the following protected information to be released:

Drug/Alcohol Information	Yes_____	No_____
Mental Health Information	Yes_____	No_____
AIDS/HIV Testing & Results	Yes_____	No_____
Sexually Transmitted Diseases Test/Results	Yes_____	No_____
Communicable Diseases	Yes _____	No_____
Genetic Testing	Yes_____	No_____

and is limited to the time period from _____ to_____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise specified, this authorization will automatically expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or receive copies of the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. A copy of this authorization shall be as valid as the original.

SIGNATURES: _____

Requesting Party_____ Date_____