Temecula Valley OB/GYN
Medical Associates, Inc.
OBSTETRICS • GYNECOLOGY • INFERTILITY

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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. **There will be a $15.00 charge for all records released to patients.**

AUTHORIZATION

I hereby authorize: _____
Name (where you are requesting records **FROM)**

_____
Address

_____ _____ _____
City State Zip Code

_____ _____
Telephone Number Fax Number

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 (where you want your records **SENT TO**)

_____
Address

_____ _____ _____
City State Zip Code

_____ _____
Telephone Number Fax Number

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 _____ (initial) Tests for Antibodies to HIV _____ (initial)
Psychiatric/Mental Health _____ (initial) HIV Diagnosis/Treatment _____ (initial)

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

RESTRICTIONS

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.

TIME Copies will be released within fifteen (15) days after receiving a written request.

_____ _____
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 Name Witness Signature