APOLLO PHYSICIANS MEDICAL GROUP
8191 TIMBERLAKE WAY, SUITE 200, SACRAMENTO CA 95823

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.

AUTHORIZATION

I hereby authorize: _____
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:
Apollo Physicians Medical Group
8191 Timberlake Way Suite #200
Sacramento, CA 95823

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 from: _____ to _____ .

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* Relationship *if other than patient*

_____ _____
Patient's Name (PRINT) Date

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