Newport Beach OB/GYN Medical Group, Inc.

351 Hospital Road, Suite 316, Newport Beach, CA 92663

Tel # 949/ 642 – 5775; Fax # 949/ 642 – 2037

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 minor, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION: I hereby authorize: _____

_____ _____

(Name of the Practice or Facility) **(Fax Number)**

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment or diagnosis, including x-rays, correspondence and/or medical records including those from my other health care providers that above named health care provider may hold, by means or mail, fax, or other electronic methods.

TO: (Name of the Practice or Facility)

_____ **Phone Number:** _____ **Fax Number:** _____

Address: _____

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) HIV Diagnosis/Treatment _____ (Initial)

Psychiatric/Mental Health _____ (Initial) Genetic Information _____ (Initial)

Test for antibodies to HIV _____ (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 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.

_____ _____

(Signature of Patient or Legal Representative) **(Relationship if other than patient)**

Patient Name (PRINT): _____ **DOB:** _____

Date: _____