AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release/obtain 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 and require specific authorization.*

AUTHORIZATION

I hereby authorize: **COASTAL GASTROENTEROLOGY FAX 760-635-5972**

To release/obtain information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/pr medical records by means of mail, fax or other electronic methods.

To: _____
PHYSICIANS 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/Treatment)
[ ] Limited to the following medical information:_____

I also consent to the specific release/obtain 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 effective for ***One year***

RESTRICTIONS

Permissions for further use of 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

_____ _____
Witness Name Witness Signature