



**PATIENT 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.*

**AUTHORIZATION**

I hereby authorize: **El Camino Women's Medical Group**  
**2500 Hospital Dr. Bldg 8A**  
**Mountain View, CA 94040**

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

(Doctor or Group name)

(Phone)

(Address)

(City)

(State)

(Zip)

(Fax)

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)
Tests 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 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 Date of Birth

\_\_\_\_\_  
 Witness name

\_\_\_\_\_  
 Witness signature