



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: _____
 (Name) (Phone) (DOB) (Doctor or Group name)

 (Address) (City) (State) (Zip) (Fax)

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:

- Dr. Azad Dr. Balassiano Dr. Gupta
- Dr. Lam Dr. Teng
- El Camino Women's Medical Group**
- 2495 Hospital Dr. Ste 670**
- Mountain View, CA 94040**
- 650-396-8110 (Phone)**
- 650-336-7359 (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

 Witness name

 Witness signature