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.*

I hereby authorize: _____
DOCTOR/HOSPITAL

_____
ADDRESS

_____
PHONE NUMBER/FAX NUMBER

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE FROM/TO:

MELISSA PRZEKLASA AUTH, M.D.

30131 Town Center Drive Suite # 237, Laguna Niguel, CA 92677
Office: (949) 495-6100 Fax: (949) 354-0612

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:
Genetic Information _____(initial)
Drug/Alcohol/Substance Abuse_____(initial)
HIV Diagnosis/Treatment _____(initial)
Tests for Antibodies to HIV _____(initial)
Psychiatric/Mental Health _____(initial)

DURATION:
This authorization shall be effective immediately and remain in effect until: _____

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.
PATIENT'S NAME: _____DATE OF BIRTH: _____
ADDRESS: _____
PHONE NUMBER: _____

Signature of patient *or legal/personal representative*: _____
Relationship *if other than patient:* _____

DATE: _____