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: Special authorization is required to release records related to minors, HIV status, psychiatric/mental health care, and substance use treatment.

I. Authorization to Release Information

I hereby authorize:

Provider/Facility Name: _____

Address: _____

Phone/Fax Number: _____

To release medical information **to/from**:

Melissa Przeklasa Auth, M.D.
30131 Town Center Drive, Suite #237
Laguna Niguel, CA 92677
Office: (949) 495-6100
Fax: (949) 354-0612

II. Purpose of Release

This medical information/records will be used for the following purpose(s):

_____

III. Scope of Authorization

Please select one:

- **Unlimited:** All medical records, *excluding* records related to substance use, mental health, or HIV (unless otherwise authorized below).
- **Limited:** Only the following specific medical records:

  _____

Additional Authorizations (Initial next to each that applies):

- Genetic Information __ __
- Drug/Alcohol/Substance Use Treatment __ __
- HIV Diagnosis/Treatment __ __
- Tests for HIV Antibodies ___ _
- Psychiatric/Mental Health Records __ __

IV. Duration of Authorization

This authorization is effective immediately and will remain in effect until:_____
(insert expiration date or event).

V. Restrictions

This information may not be further used or disclosed without an additional signed authorization, unless such disclosure is specifically required or allowed by law.

A photocopy or facsimile of this signed authorization is as valid as the original.

VI. Patient Information

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

VII. Signature

Signature of Patient or Legal Representative:_____

Relationship to Patient (if not self):_____

Date: _____