Irvine Internal Medical Group
Authorization For Use And Disclosure Of Medical Information

I. **Patient Name:** _____ **Date of Birth:** _____

Address: _____ **Phone Number:** _____

II. **Record Location:** I authorize the healthcare provider below to release my confidential information:

HEALTH CARE PROVIDER / FACILITY NAME: _____

ADDRESS: _____

CITY, STATE ZIPCODE: _____

PHONE NUMBER: _____ FAX NUMBER: _____

III. **Record Recipient:** I authorize release of records via mail, facsimile or electronic means to:

Irvine Internal Medical Group

22 Odyssey Suite 140 Irvine CA 92618

Phone: 949-653-5810 Facsimile: 949-653-7515 **Do Not Fax Records Of More Than 50 Pages**

IV. **This Authorization Shall Apply To The Following Records:**

All health information pertaining to my medical history, mental or physical condition, treatment and diagnoses **for one year** including the following designated documents:

- ☐ LAB/PATHOLOGY REPORTS
- ☐ PROGRESS NOTES
- ☐ RADIOLOGY REPORTS (NOT FILMS)
- ☐ CONSULT REPORTS
- ☐ OTHER: _____

V. **Purpose Of Disclosure:** ☐ Patient Request ☐ Medical Treatment

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment. This authorization is effective immediately and may be revoked at any time. Revocations must be in a signed writing delivered to the requesting facility, Irvine Internal Medical Group. Revocations may not be effective to the extent that the requesting facility has acted in reliance on the authorization. California law prohibits the requesting facility from making further disclosure of my health information unless another authorization for such disclosure is obtained from me or unless disclosure is specifically required or permitted by law. I may inspect or obtain a copy of my health information that I am being asked to use or disclose, a copy fee may apply. A photocopy or 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.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Witness Signature: _____