PACIFIC CARDIOVASCULAR ASSOCIATES MEDICAL GROUP, INC.
A Professional Corporation

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

3080 Bristol Street, Suite 600
Costa Mesa, CA 92626
Fax: (714) 445-0245

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: _____
Healthcare Provider's Name and Address

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: _____
Name

_____
Address City State Zip Code

_____
Fax Email

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)
Psychiatric/Mental Health _____ (initial)
Genetic Information _____ (initial)
Tests for Antibodies to HIV _____ (initial)
HIV Diagnosis/Treatment _____ (initial)

DURATION (Not to exceed 2 years)

This authorization shall be effective immediately and remain in effect until _____Date

*If changing physician practice, please explain why: _____

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 Social Security Number Patient's Date of Birth

_____ _____
Witness Name (Print) Witness Signature