Pediatric Endocrinology Associates

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named bellow t 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: _____

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 electronic methods.

To: **PEDIATRIC ENDOCRINOLOGY ASSOCIATES**
2650 ELM AVE. SUITE 210
LONG BEACH, CALIFORNIA 90806

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) Test for Antibodies to HIV ___ (initial)
Psychiatric / Mental Health ___ (initial) HIV Diagnosis / Treatment ___ (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 obtain 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.

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

_____ _____
Patient's Name (PRINT) Patient's Date of Birth Date

_____ _____
Witness Name Witness Signature