



THE CAPITAL DERMATOLOGY MEDICAL GROUP

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AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

Patient Name: _____

Unit Number: _____

Date: _____ Birthdate: _____

A. EXPLANATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, section 56, et seq., California Civil Code.

B. AUTHORIZATION

I hereby authorize _____

(Name of Physician, Hospital or Health Care Provider)

to furnish _____
(Name of Requesters and Address)

_____ medical records and information pertaining to medical history, mental or physical condition, services rendered or treatment of _____
(Name of Patient)

This authorization is limited to the following medical records and type of information:

- a) Medical information related to _____
- b) All medical information, except, if applicable, that relates to HIV information _____
- c) All medical information including but not limited to HIV and related information _____

C. USES

The requester may use the medical records and type of information authorized only for the following purposes:

D. DURATION

This authorization shall become effective immediately and shall remain in effect until _____
(Date)

E. RESTRICTIONS

I understand that the requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

F. ADDITIONAL COPY

I further understand that I have a right to receive a copy of this authorization upon request and that a copy of this document is as valid as the original. Copy requested and received: YES _____ NO _____ Initial _____

G. SIGNATURE

Date Signed: _____
(Patient/Representative/Spouse/Financially Responsible Party)

If signed by other than Patient, indicate relationship:

Witness