SAINT JOHN'S PHYSICIAN PARTNERS

SANTA MONICA FAMILY PHYSICIANS

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Authorization for Use and Disclosure of Medical Information

This authorization allows the health care provider(s) named below to release confidential medical information and records.

Authorization

I hereby authorize: ____
Physician Name Phone Fax

____
Address City State Zip Code

To release information regarding my, or my minor child(ren) (names listed below), medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-ray, correspondence and/or medical records by means of mail, fax, or other electronic methods (if available).

Patient name:______________________________Date of birth__________

Patient name:______________________________Date of birth__________

To: ____
Name

____
Address

____
City State Zip Code

This authorization is:

[ ] Unlimited (all records, excluding substance abuse, mental health, HIV diagnosis/Treatment)

[ ] Limited to the following medical information: ____________________

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 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.

______________________________ ______________________________
Signature of Patient/Parent or Legal/Personal representative Relationship to minor, if applicable

____
Date

It is the policy of this medical practice that we will adopt, maintain, and comply with our Notice of Privacy Practices, which shall be consistent with HIPPA and California Law