AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize ____
(Name of Physician, Medical Group or Hospital)

_______________________ _______________ _______ _______ _______
Address City State Zip Telephone

to release my medical records to : **Dr. Robert Sears**
26933 Camino de Estrella, Suite A, Capistrano Beach, CA 92624
Phone: (949) 493-5437, Fax: (949) 493-0535

I understand that I have the right to limit the type of information released from my medical records as in the case of HIV test results, mental health information and alcohol and drug abuse information. The following information is to be released:

- o *I have no limitations on the information to be released from my medical record including any information concerning AIDS or results of HIV testing, psychological or psychiatric treatment, and/or alcohol or drug abuse.*
- o *The information to be released from my medical records* ***shall be limited*** *to:*

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The reason for requesting that my medical records be copied is:

_____Changed Insurance _____Second Opinion _____Personal Use

_____Changed Doctor _____Legal Case _____Unhappy with Care/Service

_____Moving Out of Area _____Accident/Third Party Liability _____Other_______________

I agree to pay a reasonable charge to cover the cost of clerical costs incurred in making the records available for inspection. In addition, I understand that I may be charged a copying fee of up to $25.00 for standard documents, and the cost of postage.

I understand that I may receive a copy of this authorization. This authorization is effective now and will remain in effect for six (6) months from the date signed or ______________. I understand that requestor 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.

Patient Name: ______________________________ Date of Birth: ____________________

Address: ______________________________ Soc. Sec. No.: ____________________

City: ______________________ State: _____ Zip: ________ Phone: ________________

Signed: ____ Date: ________________
(Signature of Patient/Parent/Patient's Legal Representative*)

Relationship to Patient: ______________________________________

*Authorized representative must submit copies of legal documents supporting assignment of this authority.

This authorization for use of 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.se., California Civil Code.

Effective January 1, 1983, California law guarantees patients access to their medical care and specifies available procedures. *Health & Safety Code 1795* et. Sec. declares that "every person having ultimate responsibility for decisions respecting his/her own health care also possesses a concomitant right of access to complete information respecting his/her condition and care provided."

In compliance with *California's Health & Safety Code 1975.12*, it is our policy to allow current and former adult patients, parents of minor patients (with exceptions), patient guardians or conservators, and deceased patient's beneficiaries or personal representatives to *inspect* the patient's medical record **within five working days** after receiving a written request or to ensure that copies are *transmitted* **within 15 days after** receipt of the written request and payment of reasonable clerical costs.