

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Dr. Robert Sears, 26933 Camino de Estrella, Suite A, Capistrano Beach, CA 92624, (949) 493-5437 office, (949) 493-0535 fax

to release my medical records to : _____
(Name of Physician, Medical Group or Hospital)

_____ Address _____ City _____ State _____ Zip _____

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:

G *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.*

G *The information to be released from my medical records shall be limited to:*

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 be 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 quarantees 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.