Senior Care
MEDICAL ASSOCIATES, INC.

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

_____ _____
Phone Number Fax Number

To release medical records to(Please check one):

____ Dr. Lori Clark **FAX** (844) 883-0105 ____ Dr. Nermine Morcos-Clark **FAX** (844) 883-0119

____ Dr. Tommy Hicks **FAX** (844) 883-0107 ____ Dr. Jorge Rivero **FAX** (844) 883-0117

____ Dr. Homer Lew **FAX** (844) 772-0262

This authorization is:

- ❑ For all records
- ❑ Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial) Tests for HIV _____ (initial)

Psychiatric/Mental Health _____ (initial) Genetic Information _____ (initial)

DURATION

This authorization shall be effective immediately and remain in effect either permanently **or**

until:_____.
Date

This authorization allows the healthcare provider(s) named above to 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.*

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

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