AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize: Previous Physician/ Healthcare Facility:

Name:_____

Phone:_____ Fax:_____

To release medical records to (Please check one):

__Dr. Lori Clark FAX (844) 883-0105 __ Dr. Nermine Morcos-Clark FAX (844) 883-0119

__Dr. Jorge Rivero FAX (844) 883-0117 __Dr. Hadi Mansoury FAX (833) 428-6179

__Dr. Homer Lew FAX (844) 772-0262 __Dr. Mohana Kulkarni FAX (833) 973-0752

__Dr. Cecilia Tran FAX (833) 455-6366 __Dr. Curtis Siu FAX (833) 455-6367

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 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.

X_____ **X**_____

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

X_____ **X**_____ **X**_____

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