



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

___ Dr. Sarah Teymoorian **FAX** (855) 372-7416

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