

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below 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..

I hereby authorize: (Physician name) _____
(Address) _____

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and /or medical records by means of mail, fax or other electronic methods.

To: **GRACE MEDICAL GROUP OF THE VALLEY, INC. & AFFILIATED PROVIDERS**
CRAIG Y. ENDO, M.D.
TIFFANY P.L. ENDO, D.O.
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POMONA, CA 91767
TEL: (909) 392-3230
FAX: (909) 392-3224

This authorization is:

_____ Unlimited (all records, excluding Substance Abuse, Mental health, HIV Diagnosis/Treatment)

_____ Limited to the following medical records _____

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

_____ Drug/Alcohol/Substance Abuse _____ HIV Tests

_____ Psychiatric/Mental Health _____ HIV Diagnosis/Treatment

DURATION: This authorization shall be effective immediately and remain in effect until _____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

Signature of patient or legal/personal representative

Relationship if other than patient

Print Patient's Name

Date

Patient's Social Security Number

Patient's Date of Birth