Orange Psychiatric Medical Group, Inc.

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.*

AUTHORIZATION

I hereby authorize: _____

Physician/Healthcare Facility

_____

Address

_____

City   State   Zip Code

_____

Phone Number   Fax Number

To release information on (Patient's Name)_____

(Patient's DOB) _____ regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above-named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____

Name

_____

Address

_____

City   State   Zip Code

_____

Phone Number   Fax Number

The medical information/records will be used for the following purpose:

_____

This authorization is:

[   ] Unlimited (all records)

[   ] Limited to the following medical information:

_____

_____

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

Drug/Alcohol/Substance Abuse   _____(initial)

Psychiatric/Mental Health   _____(initial)

Tests for Antibodies to HIV   _____(initial)

HIV Diagnosis/Treatment   _____(initial)

Genetic Information   _____(initial)

From: Date of Service_____ To: Date of Service_____

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.

I have been advised of my right to receive a copy of this authorization.

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

_____   _____
Patient's Name (PRINT)   Date

_____   _____
Patient's Social Security Number   Patient's Date of Birth

_____   _____
Witness name   Witness signature