AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize ______________________________, M.D. to furnish medical information concerning ______________________________ (patient) to ______________________________

_____(name and address of person to receive records).

Any and all information may be released, including but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below: ______________________________

The information may be used only for the following purposes:* ______________________________

This authorization is effective now and will remain in effect until____________ (date).

I understand that I have the right to receive a copy of this authorization.

Signed: ______________________ Dated: ______________________

Print Name: ______________________

If not signed by the patient, please indicate relationship:

[] parent or guardian of minor patient (to the extent minor could not have consented to the care)

[] guardian or conservator of an incompetent patient

[] beneficiary or personal representative of deceased patient **

[] spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

*Signed: ______________________ Dated: ______________
Treating Physician

** For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both patient's treating physician and the patient sign the authorization form before information may be released.*

*** It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain records containing HIV test results.*