Garey Orthopedic Medical Group
2776 N. Garey Ave, Pomona Ca 91767, 7777 Milliken Ave Ste 101 Rancho Cucamonga Ca 91730
Ph (909) 593-7437/ Fax (909) 593-0318

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

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

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

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] 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)**

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**