



AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and reports. *Note: Information and records regarding minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorizations.*

I hereby authorize: **Comprehensive Care Center of Irvine, Inc.**
250 East Yale Loop, Suite 204
Irvine, CA 92604
Phone: (949)732-3530 Fax: (949)732-3533

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: Name: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

This medical information / records will be used for the following purpose:
 Change of Primary Care Physician Consult with Specialist Other _____

This authorization is:
 Unlimited (all records including Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
 Limited to the following medical information:
 Last 2 years of records (progress notes, test results, procedures, immunizations)
 Test Results
 Immunizations
 Other: _____

This authorization shall be effective immediately and remain in effect until _____.
Permission 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, Guardian / Legal Representative

Relationship (if other than Patient)

Patient's Name (PRINT)

Date of Request

Patient's Social Security Number

Patient's Date of Birth

Witness

Date Records Sent