EL CAMINO UROLOGY MEDICAL GROUP INC.
A Division of USNC

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 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 Code

Phone:_____ Fax: _____

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)
Tests for Antibodies to HIV_____(initial)
Psychiatric/Mental Health _____(initial)
HIV Diagnosis/Treatment _____(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 of 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.

There will be a $35.00 fee if additional copies are requested.__(initial)

_____ _____

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

_____ _____

Patient's Name (PRINT) Date

_____

Date of Birth

There will be a $35.00 fee if additional copies are requested. _____ (initial)