AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) name 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: **West Coast OB/GYN** | 7695 Cardinal Court Suite 240 San Diego, CA 92123
Phone Number: (858) 277-9378 | Fax Number: (858) 277-9370
Email: wcobgyn@encryptedmedicaldata.com

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 or fax, mail, or other electronic methods.

To send records to: _____ _____
Name/Healthcare Facility *Phone number*

_____
Address

_____ _____
Fax number *Email address*

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 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 _____

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 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.

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

_____ _____
Patient's Name (PRINT) Date

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

_____ _____
Witness Name Witness Signature