AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please **REQUEST** Medical Information **FROM:**

Name of Health Care Provider

Name of Medical Office or Hospital

Street Address

City, State and Zip Code

Please **SEND** Medical Information **TO:**

Jean-Claude Hage, M.D.
399 E. Highland Ave.
Suite 222
San Bernardino, CA 92404

Phone: 909-886-4917
Fax: 909-886-0699

I hereby authorize _____ **to release and/or disclose the medical information as indicated below to the health care provider indicated above.**

Release and/or disclosure records and information regarding:

Name of Patient (List Other Names Used) _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____ Telephone (____)_____

DURATION: This authorization shall become effective immediately and shall remain in effect until_____ *(enter date)* or for one year from the date of signature if no date is entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED:
Check the box and initial which type of information is to be released and/or disclosed:

- ☐ **General Medical Information** *(from_____ to_____)*
- ☐ **X-Ray (check one or both):** ☐**Films** ☐**Reports**
- ☐ **Laboratory Results**
- ☐ **Mental Health** *(from_____ to_____)*
- ☐ **Alcohol/Drug** *(from_____ to_____)*
- ☐ **HIV Test Results** *(from_____ to_____)*
- ☐ **Other (specify)** _____

_____ _____
Signature of Patient or Representative Date

_____ _____
Signature of Patient or Representative Date

_____ _____
Signature of Patient or Representative Date

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only:_____
A copy of this authorization is valid as an original.

Date _____ Signature of Patient or Patient's Representative _____ Relationship (if signed by Other than Patient) _____