South Coast Medical Group

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AUTHORIZATION FOR USE/DISCLOSURE OF HEATLH INFORMATION

Name: _____ Date of Birth: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provider named below to disclose my health information during term of this Authorization to the recipient that I have identified below.

Name of Provider: _____
Address of Provider: _____
_____
Phone/Fax# _____

Recipient and Address for Delivery of Records:

Purpose: I understand that the specific purpose of this authorization is:

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

____ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above named health care provider may hold

____ All of my health information described above except for the following:
_____

____ Only the following records or types of health information: (insert dates of treatment, types of treatment or other designation

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Term: This authorization will remain in effect for one (1) year from the date this authorization is signed

_____ _____
Patient Signature Date

Please be advised that there will be a charge from SCMG to send records when they are being sent without a referral from SCMG.