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: THEODORE J. CALIENDO, M.D., A MEDICAL CORPORATION, located at: 27800 Medical Center RD, STE 204, Mission Viejo, CA 92691-6408

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: ______________________________
Name

____
Address

____________________ ________ ________
City State Zip Code

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) HIV Diagnosis/Treatment _______(initial)

Psychiatric/Mental Health ________(initial) Genetic Information _______(initial)

Tests for Antibodies to HIV ________(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.

____
Signature of patient *or legal/personal representative*

____
Relationship *if other than patient*

____
Patient's Name (PRINT)

____
Date

____
Patient's Date of Birth

____
Witness name

____
Witness signature

Rev Oct 2013