TUSTIN IRVINE INTERNAL MEDICINE GROUP, INC.

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(714) 838- 5610
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EXPLANATION: This authorization for use of disclosure of medical information is being requested for you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56 et seq., California Civil Code.

I hereby authorize____
(Name of Physician, Medical Group of Hospital)

____
(Address and Telephone number of Physician, Medical Group or Hospital)

To release my medical records to___________________________________
(Name of Physician, Medical Group of Hospital)

____
(Address and Telephone number of Physician, Medical Group or Hospital)

PURPOSE FOR RELEASE_____________________________________

INFORMATION TO BE RELEASED: Please check all that apply
___Complete medical records concerning my illness/treatment
___Operative records ____Lab/Xray reports____Other

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I understand that I have the right to limit the type of information released from my medical records as in the case of HIV, AIDS, mental health, alcohol or drug abuse information. I have no limitations of the information to be released From my medical records concerning HIV, AIDS, psychological, psychiatric, alcohol or drug abuse.
PLEASE CHECK ONE_______AGREE ________DISAGREE

This authorization is effective immediately and is subject to revocation at any time, except to the extent that actions has already been taken. Otherwise, this authorization expires 60 days from the date of signing. I have been advised of the Medical Information Act confidentiality of the information in these records. I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released.

I further release my attending Physician, consultants, facility and employees from any liability arising from the release of information to the person, persons/agency designated above.

I understand that I have a right to receive a copy of this authorization upon my request.

PRINT PATIENT NAME ______________________ BIRTHDATE____________

PATIENT ADDRESS________________________ TELEPHONE____________

SIGNATURE_____________________________ DATED____________
(PATIENT/PARENT/PATIENTS LEGAL REPRESENTATIVE*)

RELATIONSHIP TO PATIENT_________________________________
Authorized representative must submit copies of legal documents supporting assignment of this authority.