Authorization for Release of Medical Information

Authorization for use/or disclosure of Protected Health Information.

I hereby authorize **Lakewood OMF Surgery, Inc.**
(name of disclosing party)

4448 E. Village Road
Address

Long Beach **CA** **90808** **(562) 421-9369**
City State Zip Telephone

To disclose _____
(name of recipient)

Address

_____ _____ _____
City State Zip

_____
Phone

Name of Patient_____ DOB_____

Check the box and initial to specify which type of information is to be disclosed.

- o Medical Information _____ Start Date _____to End Date_____
- o X-Ray Results _____ Start Date _____to End Date_____
- o Lab Results _____ Start Date _____to End Date_____
- o Progress Notes _____ Start Date _____to End Date_____
- o Consultation Reports _____ Start Date _____to End Date_____
- o Other _____ Start Date _____to End Date_____

Specify the records to be disclosed:

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here_____.

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.
Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorized Representative of Patient:
Signed_____
Name_____
Relationship to Patient_____

Witness:
Signed_____
Name _____
Patients _____