MERCED OBGYN CARE, INC.
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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 HIV diagnosis/treatment, or genetic information have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: ________________________________ (Physician/Healthcare Facility) to release information regarding ______________________________ (Patient's Name) _______________ (Patient's DOB) containing medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other healthcare providers that the above named healthcare provider may hold, by means of mail, fax, or other electronic methods, to:

Name: ____
Address: ____
City: ________________________________ State: ______ Zip Code: _______________

This authorization is:

[ ] Unlimited (all records, excluding HIV Diagnosis/Treatment and Genetic Information)
[ ] Limited to the following medical information:

____

I also consent to the specific release of the following records:

HIV Diagnosis/Treatment ______ (Initial)
Genetic Information ______ (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 the patient or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

____
Signature of Patient *or Guardian if Minor*

____
Relationship to Patient

____
Patient's Name (Print)

____
Date

____
Patient's Date of Birth