Authorization for Release of Medical Records

Patient Name____

SSN ___________-_________-__________

This authorization to receive or release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56, et seq., of the California Civil Code.

I hereby authorize ____

____

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To furnish to:

Robin Wedberg, M.D.
5030 Camino de la Siesta, Ste. #106
San Diego, CA 92108
Phone (619) 220-0999 Fax (619) 220-8567

medical records and information pertaining to medical history, treatment, physical examination, and hospitalization:

____ ______________________
PRINT – name of patient Date of birth

I understand this information supplied will be used for the following purpose(s):

____

I understand that this form does NOT authorize the release of any medical information concerning HIV test results and/or treatments, sexually transmitted diseases, psychiatric care, psychological assessment and/or treatment, drug or alcohol abuse treatment.

I understand that the release or transfer of the information specified above to any person or entity not specified above is prohibited.

I understand that the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that I may revoke this consent at any time except to the extent that action has already been taken. This authorization shall become effective immediately and shall remain in effect for one year.

____ ______________________________
Signature of patient Date

____ ______________________________
Signature of patient's legal representative (if applicable) Legal representative's relationship to patient