

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 _____

To furnish to: **Robin Wedberg, M.D.**
3636 4th Ave #215
San Diego, CA 92103
Phone (619) 220-0999 Fax (619) 794-2942

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