AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

AUTHORIZATION

I hereby authorize: Long Beach Internal Medical Group Inc.

2650 Elm Ave. Suite 309 Long Beach,CA 90806

Phone(562)595-8549 FAX(562)492-6271

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods:

To: ____

Name

____

Address

____ ________ ____________

City State Zip Code **Phone/Fax Number**

The medical information/records will be used for the following purpose:

____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information:

____

I also consent to the specific release of the following records: Genetic Info_______(initial) Drug/Alcohol/Substance Abuse________(initial) Tests for Antibodies to HIV ________(initial) Psychiatric/Mental Health ________(initial) HIV Diagnosis/Treatment ________(initial)

DURATION: This authorization shall be effective immediately and remain in effect until one year after date signed.

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

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

I have been advised of my right to receive a copy of this authorization.

_________________________________ ______________________

Signature of Patient *or legal/personal representative and Relationship* ***Date***

_________________________________ ____________________________

Patient's Name (PRINT) **Patient's Date of Birth**

Copy Fee:

There is no fee for the first request of records

Any subsequent request will be $25.00

Copy fee to be paid prior to receiving records