

Alamo Hills Medical Group, Inc.  
2876 Sycamore Dr., Suite 101  
Simi Valley, CA 93065  
(805) 527-6424 Fax (805) 522-0115

**AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION**

I hereby authorize \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone Number \_\_\_\_\_

To release confidential medical information and records regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis, prognosis, including x-ray, correspondence and/or medical records by means of mail, fax or other electronic methods. Note: **Information and records regarding treatment of HIV have special rules that require specific authorization.**

This authorization is:

- Unlimited (all records, excluding HIV diagnosis/treatment)
- Limited to the following medical information \_\_\_\_\_
- Immunizations only
- For a specific time period from \_\_\_\_\_ to \_\_\_\_\_

I also consent to the specific release of tests for antibodies to HIV \_\_\_\_\_ initials

To: \_\_\_\_\_  
Name

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Restrictions:** Permission for further use and 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 a 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 \_\_\_\_\_ Relationship if other than patient \_\_\_\_\_

Patient Name (PRINT) \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone Number \_\_\_\_\_

Witness Name (PRINT) \_\_\_\_\_ Witness Signature \_\_\_\_\_

- Patient will pick up copies
- Copies to be mailed to patient
- Copies to be mailed to: \_\_\_\_\_