Medical Release Form

This authorization allows the healthcare provider(s) names below to release confidential medical information and records.

Authorization:

I herby authorize: Physician/Healthcare Facility ______________________________

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Phone#__________________ Fax#__________________

To Release Medical Records To:

___Michael Z. Kurtz, D.O. ___Lynn Uchizono, PA-C ___Tiffany Nguyen, PA-C
12495 Valley View St
Garden Grove, CA 92845
Phone# 714-897-9355 Fax# 714-897-5117

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

Drug/Alcohol/Substance Abuse___ Tests for Antibodies to HIV___
Psychiatric/Mental Health___ HIV Diagnostic/Treatment___

DURATION: This authorization shall be effective immediately and remain in effect until__________

______________________________ Patient Name (PLEASE PRINT)

______________________________ Relationship if other than patient

______________________________ Date of Birth

______________________________ Social Security Number

______________________________ Signature of patient or legal/personal representative

______________________________ Date Signed

Permission 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 photo copy of facsimile of this authorization shall be considered as effective and valid as the original