AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.
Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require special authorization.

I authorize: Doctor: _____

Address:_____

City, State, Zip Code: _____

to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health providers that the above named care provider may hold, by means of mail, fax or other electronic methods to:

Vascular And Interventional Specialists of Orange County
1010 W. La Veta Avenue, Suite 320, Orange, CA 92868
Phone: 714.560.4450 Fax: 714.560.4455

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:

Drug/Alcohol/Substance Abuse _____ (initial)
Psychiatric/Mental Health _____ (initial)
Genetic Information _____ (initial)
Tests for Antibodies to HIV _____ (initial)
HIV Diagnosis/Treatment _____ (initial)

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 or facsimile of this authorization shall be considered effective and valid as the original.
I have been advised of my right to receive a copy of this authorization.

PATIENT NAME: _____

DATE OF BIRTH: _____

SIGNATURE: _____
(Patient, Parent or Legal Guardian)

PRINTED NAME/RELATIONSHIP: _____
(Parent or Legal Guardian)

Expires 1 year of the date of signature but may be revoked sooner if done in writing