



## AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

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

**AUTHORIZATION**

I hereby authorize: **REDLANDS OB/GYN ASSOCIATES**  
 SAMIR E. HAGE, D.O., INC.  
 255 TERRACINA BLVD, SUITE 202  
 REDLANDS, CA 92373

PHONE: (909) 748-6065  
 FAX: (909) 748-6095

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: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

The medical information/records will be used for the following purpose: **CONTINUITY OF CARE**

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)      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 \_\_\_\_\_  
Date

**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 as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

\_\_\_\_\_  
 Signature of patient or legal representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship if other than patient

\_\_\_\_\_  
 Witness

\_\_\_\_\_  
 Date