Redlands Obstetrics and Gynecology Associates
Samir E. Hage, D.O., Inc.

255 Terracina Boulevard, Suite 202 · Redlands, California 92373
Phone: (909) 748-6065 Fax: (909) 748-6095 www.redlandsobgyn.com

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 specific authorization.*

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

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: **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

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