AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

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

AUTHORIZATION

I hereby authorize: Floyd G. Shon, MD

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 care providers that the above neamed health care provider may hold, by means of mail, fax or other electronic methods.

To: ____
Name

____
Address

______________________ _____ ______
City State Zip Code

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:____
( ) Operative records ( ) Special Studies (EMG, etc) ( ) X-Rays ( ) MRI ( ) Lab Work

I also consent to the specific release of the following records:______________________________
Drug/Alcohol/Substance Abuse______(initial) Test for Antibodies to HIV______(initial)
Psychiatric/Mental Health___________(initial) HIV Diagnosis/Treatment_______(initial)
Genetic Information________________(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 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's Name (Print) Date

____________________________________ ____________________________________
Patient's Social Security Number Patient's Date of Birth

____________________________________ ____________________________________
Witness name Witness signature