

# AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

---

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

I hereby authorize: \_\_\_\_\_  
Physician/ Healthcare Facility

\_\_\_\_\_  
Address, City, State, Zip Code

To release information regarding my medical history illness or injury, consultations, prescriptions, treatment, diagnosis, or prognosis including hospitalizations records, x-rays, correspondence and or medical records, by means of email, fax, or other electronic methods.

To: **Michael A. Waldman, M.D.**  
**2 Hughes Ste 175, Irvine, Ca 92618**  
**(949) 600-8260 Fax (949) 600-8263**

The medical information / records will be used for the following purpose of: \_\_\_\_\_

This authorization is:

( ) Unlimited (all records including substance abuse, mental health, HIV, diagnosis / treatment)

( ) Limited to the following \_\_\_\_\_

This authorization is effective immediately and will remain in effect until \_\_\_\_\_

Permission for further use or disclosure of medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required by law.

A photocopy of this authorization shall be considered as effective and valid as the original. I have been advised of my rights to receive a copy of this authorization.

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

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

\_\_\_\_\_  
Print patient name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's social security number

\_\_\_\_\_  
Patients date of birth

\_\_\_\_\_  
Witness