PLEASE MAIL ANY REPORTS OVER 15 PAGES

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 Fax #

To release information by means of mail or fax regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including, x-rays, correspondence and/or medical records that the above named health care provider may hold.

To: **NEETA AMBE-CRAIN, M.D.**
1220 LA VENTA DRIVE, SUITE 205
WESTLAKE VILLAGE, CA 91361
PH (805) 371-0770 FAX (805) 371-0773 NO FAXES OVER 15 PAGES!

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

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 of 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.

_____ _____
Signature of patient *or legal/personal representative* Relationship *if other than patient*

_____ _____
Patient's Name (PRINT) Date

_____
Patient's Date of Birth