



# La Jolla Village Family Medical Group

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## AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL INFORMATION

### A. EXPLANATION

This authorization to receive or release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Action of 1981, Section 56, et seq., of the California Civil Code.

### B. AUTHORIZATION

I hereby authorize \_\_\_\_\_  
(Name and address of physician, hospital, or healthcare provider)

To furnish to La Jolla Village Family Medical Group 8950 Villa La Jolla Dr. Suite C129, La Jolla CA 92037

(Name and address of recipient)

Medical records and information pertaining to medical history, mental or physical condition, services rendered, or treatment for

\_\_\_\_\_  
(PRINT name of patient) (Date of birth)

C. I UNDERSTAND that I have the right to limit the type of information to be released. I have indicated below the information that is authorized for release.

- ALL MEDICAL INFORMATION WITHOUT EXCEPTION, including information regarding AIDS testing, psychological or psychiatric treatment, and drug or alcohol abuse.
- All medical information EXCEPT that indicated here:
- ONLY THE FOLLOWING INFORMATION:

\_\_\_\_\_

### D. USES

This information supplied is to be used for the following purpose(s):

\_\_\_\_\_

### E. DURATION

This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (date).

### F. RESTRICTION

I understand that the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

### G. SIGNATURE

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient, Parent, Guardian, or Legal Representative of Patient)

If signed by someone other than patient, indicate relationship: \_\_\_\_\_

Witness: \_\_\_\_\_