Anna E. Lee, M.D., Medical Corporation

AUTHORIZATION TO INSPECT AND COPY PRIVATE HEALTH INFORMATION

PATIENT: _____ DOB: _____

AUTHORIZATION: I hereby authorize: _____

_____

To release information regarding my/my child's 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 named health care provider may hold, by means of mail, fax or other electronic methods.

Send to: **Anna E. Lee, M.D., Med Corp, 3998 Vista Way, Suite D, Oceanside, CA 92056, phone: (760) 295-1995, fax: (760) 295-1118**
The medical information/records will be used for the following purpose:

_____

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: **Please initial each**

Drug/Alcohol/Substance Abuse	_____	HIV Diagnosis/Treatment	_____
Psychiatric/Mental Health	_____	Genetic Information	_____
Tests for Antibodies to HIV	_____		

DURATION: This authorization shall be effective immediately and remain in effect until _____ (or for 1 year from today's date if left unspecified).

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 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 representative Relationship

_____ _____
Name (PRINT) Date

Witnessed by (office use): _____