AUTHORIZATION FOR USE AND

DISCLOSURE OF MEDICAL INFORMATION

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

AUTHORIZATION:

I hereby authorize: ____

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To release information regarding my child's medical history, illness or injury, consultation, prescriptions, treatment, diagnosis, or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: **Santosh K . Garg M.D "A Professional Medical Corporation"**

1535 W Merced Ave Suite# 300 West Covina, CA 91790

Telephone# (626 962-8122 Fax# (626) 962-8408

Copies of my health information within the following dates: _________________ to _________________

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: (date). You or your Personal Representative may revoke this authorization at any time by providing written notice as specified in our Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

RESTRICTIONS:

Permission 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.

Patient's Name: ____ **DOB:** _______________

SIGNATURE ____ **Date:**_______________

____ ____

Printed Name of Patient or Personal Representative Description of Personal Representative's Authority