AUTHORIZATION TO RELEASE INFORMATION

Patient Name:		
Patient Address:		
Medical Record Number:	Last four digits of Social Security Number:	Date of Birth: / /

I hereby authorize (physician stated below)

Physician name:	
Address:	
Phone:	Fax:

To release the following information: (Please be specific and check those that apply)

	History and Physical		Clinical and laboratory results
	Radiology		Cardio-pulmonary testing
	Inpatient/Outpatient hospital records		Physician progress notes
	Alcohol/drug abuse treatment		Mental health records
	Other (please specify):		

To:

Dr. Bernard Michlin, MD, Internal Medicine
C/O: Medical Records, 6367 Alvarado Court Suite 200, San Diego, CA 92120
Fax: (619) 583-5499 / Email: staff@bernardamichlinmd.com

This Private Health Information is being used or disclosed for carrying out treatment, evaluation, disability evaluation, payment, and/or:

_____.

TO BE READ AND SIGNED BY THE PATIENT

I understand the following:

1. This medical information may be used by the person I authorize to receive this information for medical treatment, consultation, billing or claims payment, or other purposes as I may direct.

2. This authorization shall be in force and effect until _____ (date or event) at which time this authorization expires.

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that my treatment, payment, enrollment, or eligivilty for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient signature:		Date:
Signature of Patient's Representative:	Relationship:	Date: