

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**  
 Failure to provide all information may invalidate this authorization

<b>Patient Information</b>	Patient Name: _____ Former Name: _____ MRN: _____ Date of Birth _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____	
<b>Release To</b>	I authorize Crown Surgery Medical Group to release records to: Person/ Organization: _____ Address: _____ City/State/Zip: _____	For the following reason: <input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Personal Use <input type="checkbox"/> Other: _____ _____ _____
<b>Information to Release</b>	Treatment Dates: _____ <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Billing Record <input type="checkbox"/> Physician Notes <input type="checkbox"/> Operative Reports <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Diagnostic Imaging <input type="checkbox"/> Other: _____	Based on California Evidence Code Sections 1560-1567 fees may be charged for medical record copies.
<b>Delivery Instructions</b>	<input type="checkbox"/> Fax records directly to person or organization <input type="checkbox"/> Call requestor when records are ready for pick up I authorize _____ to pick up my medical record copies. Relationship to patient: _____	
<b>Expiration</b>	Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified: _____	
<b>Signature</b>	Signature: _____ (Patient or Legal Representative) Date: _____	