

AUTHORIZATION TO RELEASE MEDICAL RECORDS

REQUESTING PARTY: Today's Date _____

Printed Legal Name _____ Date of Birth _____

I, the undersigned, hereby authorize:

Name of Agency or Doctor _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

TO RELEASE MY INFORMATION TO:

Kelly K McCann, MD, MPH & TM

1831 Orange Ave., Suite A

Costa Mesa, CA 92627

www.DrKellyMcCann.com

Information to be released:

____ ALL MEDICAL RECORDS

____ OTHER _____

Sign next to "Yes" or "No" for the following protected information to be released:

Drug/Alcohol Information	Yes _____	No _____
Mental Health Information	Yes _____	No _____
AIDS/HIV Testing & Results	Yes _____	No _____
Sexually Transmitted Diseases Test/Results	Yes _____	No _____
Communicable Diseases	Yes _____	No _____
Genetic Testing	Yes _____	No _____

and is limited to the time period from _____ to _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise specified, this authorization will automatically expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or receive copies of the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. A copy of this authorization shall be as valid as the original.

SIGNATURES: _____

Requesting Party _____ Date _____

For _____ Relationship _____