

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE:

TO RELEASE RECORDS TO:

Address _____
City/ST/zip _____
Tel _____
Fax: _____

**Nancy L. Sajben , M.D.
9834 Genesee Avenue, Suite 427
La Jolla CA 92037**

**Fax: 858.622.0550
Tel: 858.622.0500**

THE FOLLOWING MEDICAL RECORDS FOR THE PATIENT:

Patient: _____ DOB: _____

- RESULTS OF HIV TESTING*
- RECORDS RELATED TO ALCOHOL OR DRUG ABUSE*
- RECORDS RELATED TO PSYCHIATRIC OR MENTAL DISORDERS*

DISCLOSURE OF RECORD SHALL INCLUDE:

- RECENT LABORATORY STUDIES _____
- X-RAY REPORTS _____
- EMG REPORTS _____
- CONSULTATION REPORTS _____
- HOSPITAL DISCHARGE SUMMARY & OPERATIVE REPORTS _____
- INITIAL EVALUATION AND LAST THREE VISITS _____
- EKG REPORT _____
- OTHER _____

DURATION:

This authorization shall become effective immediately and shall remain in effect for 90 days unless revoked in writing.

***CONFIDENTIALITY:**

This information has been disclosed from a confidential record that is protected by state law and any further disclosure of it without specific prior written consent of the person to whom it pertains is prohibited. Violation of these confidentiality guarantees may subject you to civil or criminal liabilities.

SIGNED BY _____ RELATIONSHIP TO PATIENT _____

WITNESS _____ DATE _____