



**AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION
FOR MINORS AND/OR DEPENDENT ADULTS**

EXPLANATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981. Civil Code Section 56 *et seq.*

AUTHORIZATION

I hereby authorize San Dimas Medical Group, Inc. to furnish to:

_____ (name of requestor)

medical records and information pertaining to medical history, mental or physical condition, services rendered, or treatment of:

_____ (name of patient/other than requestor)

This authorization is limited to the following medical records and type of information:

USES

The requester may use the medical records and type of information authorized only for the following purposes:

Personal Use Medical Need Insurance Reasons Other: _____

DURATION

This authorization shall become effective immediately and shall remain in effect until _____ (date)

RESTRICTIONS

I understand that the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY

I further understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received: Yes No _____ (initials of patient)

SIGNATURE

Date: _____ Time: _____ am / pm

Signature: _____ (patient/representative/spouse/financially responsible party)

If signed by other than patient, indicate relationship: _____

Witness: _____

- Obstetrics & Gynecology**
- Marietta M. Tan, M.D.
 - Wendy Crenshaw, M.D.
 - Dana Edwards, M.D.
 - Tillaikarasi Kannappan, M.D.
 - Jigisha Upadhyaya, M.D.
 - Gregory R. Klis, M.D.
 - James Tsai, M.D.
 - Noel Del Mundo, M.D.
 - Jacqueline Williams-Olango, M.D.
 - Luis Lopez, M.D.
 - Sonia Ghai, M.D.
 - Kasey Swafford, PA-C
 - Rosa Luna, PA-C
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 - Anne Graham, FNP-C

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