SAN DIMAS MEDICAL GROUP, INC.
SERVING KERN COUNTY SINCE 1973

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Nurse Practitioners
Anne Graham, FNP-C

Physician's Assistant
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# AUTHORIZATION FOR USE AND/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 requester)

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

_____
(name of patient/other than requester)

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: _____

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