Authorization for Release of Medical Record Information

Name: _____ Date of Birth: _____
Address: _____ Medical Record No.: _____
City: _____ State: _____ Zip: _____
Telephone No.:_____

I hereby authorize:

Name: _____ Address: _____
City: _____ State: _____ Zip: _____

to disclose information from my / my minor child's medical records to (name and address):

Name: Gary Seto, MD Address: 1800 Fair Oaks Ave. Suite A
City: South Pasadena State: CA Zip: 91030
Office: 626-441-3298 Fax: 626-513-8400

I hereby authorize redisclosure of this information to:

Name: _____ Address: _____
City: _____ State: _____ Zip: _____

This information is needed for the following reason:

_____

The specific information I wish to have released is (included dates of treatment):

_____

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

_____ _____
Signature: (Parent or Legal Guardian if Minor Child) Date:

Expires: _____

Witness: _____

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

☐ I DO consent to have this information disclosed.
☐ I DO NOT consent to have this information disclosed.

_____ _____
Signature: (Parent or Legal Guardian if Minor Child) Date:

This medical record may contain information concerning HIV testing and / or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

☐ I DO consent to have this information disclosed.
☐ I DO NOT consent to have this information disclosed.

_____ _____
Signature: (Parent or Legal Guardian if Minor Child) Date: