Authorization for Release of Medical Record Information

Name: ____________________
Address: ____________________
City: ____________ State: ______ Zip: _______
Telephone No.: ____________________

Date of Birth: ____________________
Medical Record No.: ____________________

I hereby authorize:

Name: Gary Seto, MD Address: 1107 Fair Oaks Ave. #412
City: South Pasadena State: CA Zip: 91030

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

Name: ____________________ Address: ____________________
City: ____________________ State: __________ Zip: __________

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: