



# MEMORIAL SPORTS & INTERNAL MEDICINE

## Authorization For Release Of Medical Information

I hereby authorize

\_\_\_\_\_

*(Physician, Medical Group Etc.)*

\_\_\_\_\_

*(Address)*

\_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_

*(Phone)*

To release medical records to:

Memorial Sports and Internal Medicine, Inc  
10861 Cherry Street  
Suite 105  
Los Alamitos, California 90720  
Phone 562-795-6406

The following is to be released- All medical records

Please specify if you do not want portions of your medical record copied or released

\_\_\_\_\_

*(Patient name)*

*(Date of birth)*

*(Social security #)*

\_\_\_\_\_

*(Address)*

*(City and state)*

*(Zip)*

*(Phone)*

This authorization is effective now and will remain in effect until \_\_\_\_\_. This authorization will expire in six months after the date signed unless specified. This authorization is limited to the information stated above. Authorization for the release of records pertaining to drug/alcohol treatment, psychological or HIV requires a separate authorization.

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

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*(Patient signature)*

Witnessed: \_\_\_\_\_