***Amethyst Medical Group - Winni Loesch, MD, FAAFP***

***123 Margaret Lane, Ste C2 Grass Valley, CA 95945***

***Telephone (530)798-5003 Fax (530)271-2338*** [***www.amethystmed.com***](http://www.amethystmed.com)

***“It’s not just about how sick you are…It’s about how well you can be!”***



# **AUTHORIZATION FOR THE DISCLOSURE OF**

# MEDICAL INFORMATION

|  |  |
| --- | --- |
| Patient Name: | |
| Date: | Birthdate: |

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, section 56, et seq., California Civil Code. I hereby authorize:

**Amethyst Medical Group**

**Winni Loesch, MD**

**123 Searls Avenue, Ste C2**

**Grass Valley, CA 95945**

To divulge any medical information regarding my care and treatment

to the person named below.

Doctor Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone/Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* Medical information related to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* All medical information, except that relating to HIV information.
* All medical information including HIV and related information.
* All medical information for the purpose of changing medical facilities, doctors, insurance, etc.

This authorization will become effective immediately and shall remain in effect until: \_\_\_\_\_\_\_\_\_\_(must specify a date mm/dd/yy)

This authorization is effective upon receipt and can be revoked at any time by the patient with written notice to this medical office. A disclosure that has already occurred cannot be withdrawn.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Patient