MEDICAL RECORDS RELEASE

COAST MEDICAL CENTER, INC.
LINETTE WILLIAMSON, M.D.
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Encinitas, CA 92024

Authorization for use or disclosure of protected health information

As required by the Health Information Portability and Accountability act of 1996 (HIPPA) and California law, this office may not close or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your completion of this form indicates that you are giving permission for the uses and disclosures described below. Please be aware that once your information leaves this office, we will not longer be able to protect that information and the recipients of your information may not be legally required to protect your information.

I hereby authorize Linette Williamson, M.D. to obtain or disclose my health information.

I understand this information may include information relating to AIDS or HIV infection, STD's and treatment for alcohol and drug abuse.

Health information to be used or disclosed (check appropriate boxes)

□ Complete Medical Record
□ Consultation Report
□ Telephone messages
□ Physical exams
□ Psychotherapy notes
□ X-ray results
□ Laboratory results
□ Other _____

The above released information may be used for the following (check all appropriate boxes)

□ Continuing care
□ Insurance claims
□ Inspection of record
□ Personal copy
□ Legal
□ Second opinion

□ Other _____

I hereby release Linette Williamson, M.D. or Kristina Fredericks P.A.-C. of any legal liabilities that may occur from the release of this information to the party listed below.

Previous Physician Name and Address □:

_____

_____

_____

Information release to:

_____

_____

_____

I understand this authorization may be revoked in writing at any time, according to Linette Williamson, M.D. of Private Practices. Unless otherwise revoked, this authorization will expire I n six (6) months from the date of authorization.

_____
Patient's Printed Name

_____
Date

_____
Patient's Signature

_____
Date of Birth

_____
Witness