AUTHORIZATION TO RELEASE INFORMATION

LINAE HEALTHSPAN INSTITUTE, INC.
227 N. El Camino Real
Suite 203
Encinitas, CA 92024
(760) 632-0100

To: ____
Address: ____
City/State/Zip Code: ____
Telephone Number: (   ) _______ - ____________
Fax Number: (   ) _______ - ____________

Linae Healthspan Institute, Inc.
227 N. El Camino Real
Suite 203
Encinitas, CA 92024
Phone: (760) 632-0100
Fax: (760) 632-0102
info@linaehealthspan.com

THE PURPOSE FOR THIS RELEASE:
You are hereby authorized to furnish and release to Linae Healthspan Institute all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records;

Alcohol or Drug Abuse: () Yes () No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIV or HTLA-III test results or treatment: () Yes () No

Genetic Testing: () Yes () No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease related information, the information is from confidential records which are protected by state or federal laws that prohibit further disclosure with the specific written consent of the person to whom they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release Linae Healthspan Institute its employees, agents, managing members, and the attending physician (s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original. I understand that there may be a fee for this service depending on the number of pages photocopied. However, no such fee will be charged if these records are requested for continuing medical care.

Print Name: ________________________________ Date of Birth: _________________________
Address: __________________________________ City/State/Zipcode: ____________________
Signature: _________________________________ Date signed: _________________
(Patient or Legal Guardian)

Relationship to Patient: ______________________