

Dina Massry, M.D. \_\_\_\_\_

Jeffrey Eaton, M.D. \_\_\_\_\_

Jennifer Eastlack, M.D. \_\_\_\_\_

**DEL MAR M.E.D.**

A Medical Corporation

**Authorization:** I authorize the release of information pertaining to medical history, mental or physical condition, services rendered, or treatment, as described below for:

**Name of Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Social Security Number :** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Telephone ( )** \_\_\_\_\_ - \_\_\_\_\_

**Record Holder:** \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( ) \_\_\_\_\_ Phone \_\_\_\_\_ ( ) \_\_\_\_\_ Fax \_\_\_\_\_

**Records May Be Released To:** \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( ) \_\_\_\_\_ Phone \_\_\_\_\_ ( ) \_\_\_\_\_ Fax \_\_\_\_\_

**DATE OF SERVICE:** From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

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

- Discharge Summary     Pathology Report     Pathology Slides     Progress Notes
- History/Physical Exam     Laboratory Tests     Consultation reports     X-ray reports
- Operative/Procedure Reports     Photographs, videotapes, digital or other images
- Emergency Department Reports     Other (please specify): \_\_\_\_\_

**Use of Information:** The requestor may use the medical records and type of information authorized only for the following purposes:

- Continuing Care                       Second Opinion                       Personal                       Insurance Claim
- Other (Please specify): \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

I hereby authorize release of all information as stated above.