LightBridge
MEDICAL ASSOCIATES

6155 Cornerstone Court East, Suite 220
San Diego, CA 92121
Ph: 858-458-2993 Fax: 858-362-4027

Authorization to Receive Medical Information

Explanation:
This authorization to receive or release 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.

Authorization:

I _____ have been admitted as a patient of LightBridge Medical Associates and hereby authorize Physicians and Allied Healthcare Professionals/ Organizations and/or

- ❑ Other _____

to release the following medical information:

- ❑ Clinical Summary
- ❑ Current History and Physical
- ❑ Discharge Summary
- ❑ Laboratory Reports
- ❑ Operative Reports
- ❑ HIV Test Results and HIV Related Information
- ❑ Pathology Reports
- ❑ Consultation Reports
- ❑ Mental Health/Psych Reports
- ❑ Other _____
  _____
  _____
  _____

To an agent or designee of LightBridge Medical Associates for the purpose of review and evaluation in the planning and delivery of my care.

Duration:
This authorization shall become effective immediately and shall remain in effect until discharged from program.

Restrictions:
I understand that the requestor may not further use or release the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Additional copy:
I further understand that I have a right to receive a copy of this authorization upon my request.
Copy requested and received: ❑ Yes ❑ No Initial: _____

Signatures:

Signed: _____ Date: _____

If signed by other than patient, indicate relationship: _____

Witness: _____