AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize: APMG- Mark Kosins, MD and Consulting Staff **(Facility Name)**
647 Camino De Los Mares # 226 **(Street Address)**
San Clemente, CA 92673 **(City, State, Zip)**

To release to: _____ **(Specific Person)**
_____ **(Name of Facility)**
_____ **(Street Address)**
_____ **(City, State, Zip)**
_____ **(Telephone/Fax)**

Medical Records obtained during the course of treatment of the below names individual:
_____ (Patient Name)
_____ (Date of Birth)

DISCLOSURE OF RECORDS SHALL BE LIMITED TO THE FOLLOWING:

_____ History and Physical Examination
_____ Psychological Evaluation
_____ Progress Notes
_____ Discharge Summary
_____ Lab Reports
_____ Treatment Plan

Other (Specify):
_____
_____.

THE DISCLOSURE OF RECORDS IS REQUIRED FOR THE FOLLOWING PURPOSE:
_____
_____.

I understanding that I may revoke this authorization at any time except to the extent that action has been taken. Authorization will automatically expire 60 (sixty) days from the date of my signature.
I understand that the specific type of information to be disclosed may include history of drug, alcohol and/or psychiatric treatment.
Federal law (42CFR, part 2) prohibits redisclosure of this information by the recipient. Minor patients, 12-17 years of age, **and** the parent or legal guardian **must** sign the authorization.

A photocopy or facsimile transmission of this authorization may be accepted in lieu of the original.

_____ ____/____/____
Signature of Parent or Guardian (12-17) Date

_____ ____/____/____
Signature of Patient Date

_____ ____/____/____
Witness Date