Rebecca Garfinkle, D.O., FAAP
Child and Adolescent Neurologist
30131 Town Center Drive, Suite 245
Laguna Niguel, CA 92677
Phone: 949-495-9600
Fax: 949-249-7848

Authorization for Use and Disclosure of Medical Information

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.

AUTHORIZATION
I hereby authorize

Individual/Organization Name	Address	Phone Number	Fax Number

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, lab results, prior EEGs or other work ups, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: Dr. Rebecca Garfinkle, 30131 Town Center Dr., Suite 245
        Laguna Niguel, CA 92677
        Phone: 949-495-9600   Fax: 949-294-7848

The medical information/records will be used for aiding in diagnosis and treatment of the patient.

This authorization is;
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information:
_____
_____

I also consent to the specific release of the following records:
Genetic Testing _____ (initial)
Psychiatric/Mental Health   _____ (initial)
Drug/Alcohol/Substance Abuse _____ (initial)
Test for Antibodies to HIV _____ (initial)
HIV Diagnosis/treatment_____ (initial)

DURATION: This authorization shall be effective immediately and remain in effect until_____.
                                                                                            (date)

I have been advised of my right to receive a copy of this authorization.

_____   _____
Signature of Parent or Legal Guardian   Relationship

_____   _____
Print Legal Guardian's Name   Date

_____   _____
Patient's Name   Patient's Date of Birth

_____   _____
Witness Signature   Witness Printed Name