AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ___________________________DOB ____________ SSN ____________

I authorize ____________________________________ to release medical information to

Rheumatology Services Medical Group
Martin Berry, M.D.   Jeffrey Bacon, D.O.
Marsha Kaprielian, NP-C
8329 Brimhall Rd., Suite 801
Bakersfield, CA 93312
Telephone: (661) 695-8385
Fax (661) 679-6801

INFORMATION TO BE REQUESTED:
_______Discharge Summary _______Labs/X-Ray Reports _______Progress Notes
______Consultation Report _______Surgical Report _____Hospitalization Dates
OTHER: ____

THIS AUTHORIZATION IS EFFECTIVE IMMEDIATELY AND IS SUBJECT TO REVOCATION AT ANYTIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN, OTHERWISE THIS AUTHORIZATION EXPIRES 6 MONTHS FROM THE DATE ORIGINALLY SIGNED.

I am aware of and have been advised of the provisions of state and federal statues, rules and regulations in which provide for my right to confidentiality of the information in these records. I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization before any records can be released and that I may refuse to sign, but in that event, the records will not be released.

I further release my attending physician, the clinic/hospital, and employees of the clinic/hospital, from any liability arising from the release of information to the person(s)/agency designated above. A photocopy of this authorization is as valid as the original

Date__________   ________________________________
                                                      Signature of Guardian

_________________________   ____________________________________
Signature of Patient   Relationship to Patient

Rheumatology Services Medical Group
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Bakersfield, CA 93312
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME:________________________________DOB:_______________ SSN:_________

I authorize the exchange of medical information to:

Name: ____
Address____

PURPOSE FOR RELEASE: Coordination of services to above named person.

INFORMATION TO BE REQUESTED:
____Lab/X-Ray reports _____Progress Notes _____Consultation Report
Other: ____

REVOCATION AT ANYTIME, EXCEPT TO THE EXTENT THAT HAS BEEN TAKEN, OTHER WISE THIS AUTHORIZATION EXPIRES 6 MOTNHS FROM THE DATE ORIGINALLY SIGNED THIS AUTHORIZATION IS EFFECTIVE IMMEDIATELY AND IS SUBJEC TO.

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Date:_________________ ________________________
Signature of Guardian

___________________________________ __________________________
Signature of Patient Relationship to Patient