

AUTHORIZATION

RE: _____ (AKA NAMES) _____

TO: _____

- YOU ARE AUTHORIZED TO RELEASE THE FOLLOWING INFORMATION TO _____ OR TO THEIR AGENTS, SDT SERVICES, PURSUANT TO CALIFORNIA EVIDENCE CODE SECTION 1158.
- I HEREBY SPECIFICALLY CONSENT TO THE RELEASE OF ANY AND ALL RECORDS INCLUDING BUT NOT LIMITED TO MEDICAL RECORDS AND/OR REPORTS, INCLUDING THE RIGHT TO INSPECT, REVIEW, AND MAKE PHOTOSTAT COPIES OF ALL HOSPITAL RECORDS, POLICE REPORTS, RECORDS, AND PHOTOGRAPHS: SOCIAL SECURITY RECORDS REGARDING EMPLOYER AND WAGES, ANY AND ALL EMPLOYMENT AND PERSONNEL RECORDS; PAYMENT/CONTRACT RECORDS, ANY AND ALL CLAIM FILE RECORDS, ANY AND ALL ALCOHOL AND/OR DRUG ABUSE, PSYCHIATRIC TREATMENT AND/OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV).
- THESE RECORDS ARE REQUESTED FOR THE SOLE AND EXCLUSIVE USE OF _____.
- THIS AUTHORIZATION SHALL REMAIN EFFECTIVE FOR ONE YEAR FROM THE DATE SIGNED.
- PHOTOCOPIES OF THIS AUTHORIZATION ARE AS VALID AS THE ORIGINAL.
- I ACKNOWLEDGE MY RIGHT TO RECEIVE A COPY OF THIS EXECUTED AUTHORIZATION.
- I ACKNOWLEDGE MY RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME.
- I UNDERSTAND THAT THE REQUESTER MAY NOT LAWFULLY FURTHER USE OR DISCLOSE THE HEALTH INFORMATION UNLESS ANOTHER AUTHORIZATION IS OBTAINED FROM ME OR UNLESS DISCLOSURE IS SPECIFICALLY REQUIRED OR PERMITTED BY LAW.

DATE

SIGNATURE

PRINT NAME:



P.O. Box 120, Simi Valley, CA 93062
Phone: (805) 581-0031 Fax: (805) 522-3561
SDT1@sbcglobal.net