

JAMES D. WETHE, MD – American Board of Plastic Surgery  
3440 Lomita Boulevard, Suite 220 Torrance, CA 90505

**AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION**

This Authorization allows the healthcare provider named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

**AUTHORIZATION**

*I hereby authorize James D. Wethe, MD to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including xrays, correspondence and/or medical records of means of mail, fax or other electronic methods.*

To: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City State Zip Code

The medical information/records will be used for the following purpose:

This authorization is:

- Unlimited (all records, excluding substance abuse, mental health, HIV Diagnosis/Treatment)
- Limited to the following medical information: \_\_\_\_\_

DURATION: This information shall be effective immediately and remain in effect until \_\_\_\_\_ Date

**RESTRICTIONS**

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy, facsimile or electronic file of this authorization shall be considered as effective and valid as the original.

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

_____ Signature of Patient or Legal Guardian	_____ Relationship to Patient
_____ Printed Name of Patient	_____ Date
_____ Printed Name of Guardian	_____ Patient Date of Birth
Witness: _____ Printed name of Practice Representative	Witness: _____ Signature of Practice Representative