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:_____ Witness:_____
Printed name of Practice Representative Signature of Practice Representative