REJAN MCCASKILL, MD INC

320 SUPERIOR AVE, SUITE 330

NEWPORT BEACH, CA 92663

In an effort to reduce contact we are asking you request electronic copies of your records or send records to us via email. You can email all records to ROIRequests@4securemail.com. Thank you

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) 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: _____ (*Physician/healthcare facility*)

to release information on _____ *(Patient's Name)*

_____ *(Patient's DOB)* regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: **Rejan McCaskill, MD FACP**
320 Superior Ave, Suite 330
Newport Beach, CA 92663
TEL 949-791-2000
FAX 949-791-2001

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:

_____

_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse	_____ (initial)
Psychiatric/Mental Health Tests	_____ (initial)
Antibodies to HIV	_____ (initial)
HIV Diagnosis/Treatment	_____ (initial)
Genetic Information	_____ (initial)

DURATION

This authorization shall be effective immediately and remain in effect until _____ (Date)

RESTRICTIONS

Permission 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 or facsimile 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/personal representative* Relationship *if other than patient*

_____ _____

Patient's Name (print) Date

_____ _____

Patient's Social Security Number Patient's Date of Birth