LYLE D. KURTZ, M.D., INC.

Internal Medicine

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize _____ to release information about

_____ dob _____ including medical history, illness, injury, consultation, prescriptions, treatment, diagnosis or prognosis, 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: Lyle D. Kurtz M.D.
8920 Wilshire Blvd #323
Beverly Hills, CA 90211

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

This authorization is:

☐ Unlimited - all records including substance abuse _____ mental health_____ HIV_____

☐ Limited to the following medical information: _____

DURATION

This authorization shall be effective immediately and remain effective 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 of 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 Date