LYLE D. KURTZ MD, FACP
INTERNAL MEDICINE BEVERLY HILLS, CA

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize _____ to release information about

_____ dob _____
including 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 MD, FACP**
8920 Wilshire Blvd #323
Beverly Hills, CA 90211

Phone: 310-855-1551
Fax: 310-659-8773
Email: info@lylekurtzmd.com

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

_____

This authorization is:

☐ Unlimited: all records ***excluding*** ☐ substance abuse ☐ mental health ☐ HIV

☐ Limited to the following medical information: _____

DURATION

This authorization shall be effective immediately and remain effective 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 requited 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 | Today's Date