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## AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) 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 apply and require specific authorization.

**I hereby authorize:**                     **SPECIALTY CARE & SURGERY CENTER OR**  
    **Other Physician or provider (please specify):**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

**To release my confidential health information by means of mail, fax or other electronic methods to:**                     **SPECIALTY CARE & SURGERY CENTER OR**  
    **Other Physician or provider (please specify):**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

The medical information will be used for the following purpose:

\_\_\_\_\_  
This authorization is  Unlimited     Limited to the following medical information:

\_\_\_\_\_  
This authorization shall be effective immediately and will remain in effect until \_\_\_\_\_ or for one year from the date of signature.

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

_____ Print Patient's Name	_____ Date of Birth
_____ Signature of Patient or legal/personal representative	_____ Date