

AUTHORIZATION FOR RELEASE OF INFORMATION
FOR MEDICAL, HOSPITAL OR OTHER HEALTH CARE
OR HEALTH SERVICES PROVIDER'S RECORDS
INCLUDING
PSYCHIATRIC, DRUG, OR ALCOHOL TREATMENT RECORDS
[WELFARE & INST. CODE SEC. 5328(f) & (j)]

TO: _____

RE: NAME: _____
DATE OF BIRTH: _____
SOC. SEC. NO.: _____

This is to authorize the above-named to furnish the law office of _____, or [his/her] representative, any and all information or opinions [he/she] may request regarding my physical, mental or emotional condition and treatment and to allow [him/her] to inspect and copy any records, X-rays, or other documents or things in your custody or control regarding my condition or treatment.

These documents are necessary to the administration of justice [Welfare & Inst. Code §5328(f)] and will be disclosed only as needed for the pending litigation.

I hereby waive the right to refuse disclosure under Evidence Code §§1014 & 1016.

This authorization cancels any prior authorizations and is effective for five years, unless I revoke it in writing. I hereby acknowledge receipt of a copy of this document.

DATED: _____

NAME