COR Medical Group, Inc.

Authorization for release of medical information

PATIENT INFORMATION (please **print** clearly):

Patient Name: _____ Date of Birth: _____

Telephone #: _____ Social Sec #: _____

I, hereby authorize (circle one):

Mark K. Urman, M.D. **Jeffrey F. Caren, M.D.**

COR Medical Group, Inc.
8635 West Third Street #890W
Los Angeles, CA 90048
310-659-0714 fax 310-659-0664

To disclose and release copies of my medical records to:

(New doctor)_____, located at:

Address:_____

City, State, Zip: _____

Phone Number:_____

Fax Number: _____

Duration: I understand that this authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here_____.

Revocation: I understand that this authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party of others have acted in reliance upon this authorization.

I understand that a photocopy or facsimile of this authorization will be considered as valid as the original.

I will be fully responsible for any delay caused by failure to complete this form accurately and entirely.

I understand that a copy of the requested records will be sent to the destination I have specified.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AS THEY APPLY TO ME. I CONSENT TO THE RELEASE OF RECORDS FOR THE PURPOSE STATED ABOVE.

Signed _____ Date _____
(Patient or Authorized Representative of Patient)