CLANCY MEDICAL GROUP • 2375 S. MELROSE DR., VISTA CA 92081-8788

MASKELL, STUART C (id #1973, dob: 09/10/1964)

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: **STUART MASKELL** Previous Name: ______________

Date of Birth: **09/10/1964**

I hereby authorize the release and disclosure of my records from:

____

(Name / Address/ Phone number of current healthcare provider)

to Healthcare/Organization authorized to *receive* the information (name and address of entity):

Clancy Medical Group
2375 S. Melrose
Vista, CA 92081

This Authorization applies to the following specific information to be disclosed (select from the following)?

☑ All health information pertaining to any medical history, mental or physical condition and treatment received. Dates include: ______________

[Optional] Except for these specific limitations:

☐ Only the following records or specific types of health information. Dates include: ______________

☐ Other (please specify) ______________

I understand that this will include information relating to (check if applicable):

☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection

☐ Psychiatric Care (patient to initial here________)

☐ Treatment for alcohol and/or drug abuse.

EXPIRATION

This Authorization expires [on the following specific date]: 30 days

ADDITIONAL RIGHTS AND REQUIREMENTS IF REQUESTOR SEEKS THIS AUTHORIZATION

I understand that if Requester seeks this authorization:

1. My health information will be used for the following purpose(s): ☑ Continuing Medical Care

SIGNATURE

Signature Stuart Maskell Date/Time 10/29/2021 9:15am AM/PM

[Patient/representative/spouse/financially responsible party]

If signed by someone other than the patient, state your legal relationship to the patient:

____

Witness: ______________

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)

Clancy Medical Group
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P:(760) 305-1900 F:(760) 305-1910

MASKELL, STUART 09/10/64 #1973

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