Sonia Rebeles, MD

4201 Torrance Blvd Suite 480
Torrance CA 90503
PH: 424-571-5070 Fax: 424-358-5005

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please REQUEST Medical Information **FROM:**	Please SEND Medical Information **TO:**
_____	Dr. Sonia Rebeles
Name of Health Care Provider	Name of Health Care Provider
_____	424-571-5070
Phone number	Phone number
_____	424-358-5005
Fax number	Fax Number

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the healthcare provider, entity, or person I have indicated above.

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (date) or from one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

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

SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED: Check the box and initial which type of information is to be released and/or disclosed:

- ☐ General medical information
- ☐ Information regarding specific treatment: _____
- ☐ Pap results
- ☐ Operative reports, surgical pathology
- ☐ Other (specify): _____

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only: _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.

_____	_____	_____
Date	**Signature of Patient or Patient's Representative**	Indicate relationship (if signed by other)

Name: _____ **Date of Birth**:_____
(please print full name)