Thomas Susko M.D., Inc.
2021 Santa Monica Blvd #200e
Santa Monica, CA 90404
Phone: (310) 829-5557
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Good Medicine Takes Time

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name (please print):	**Date of Birth:**
Address:	
Phone Number:	**E-mail:**

Guardian or Legal Representative Name (please print):	**Relationship to Patient:**
Address:	
Phone Number:	**E-mail:**

I hereby authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, and family member to release all health information about me.

Person/Organization to Release Information:	
Address:	
Phone Number:	**Fax Number:**

The following person/organization is hereby authorized to receive my entire medical record, treatment record, and diagnostic record. Please send these records to the following person or organization:

Person/Organization to Receive Information:
Dr. Thomas Susko
Address:
2021 Santa Monica Blvd., Suite 200e, Santa Monica, CA 90404
Phone Number:
(310) 829-5557

With my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization. The following health information that relates to service beginning from (date): _____ to _____, may be released:

- Entire medical record including patient history, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers

I further understand that my medical record may include one or more of the following:

- Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis
- HIV-related treatment
- Mental health information or psychological conditions
- Alcohol or substance abuse treatment
- Genetic testing

The aforementioned person/organization, its' employees, representatives, and any other persons performing services for them or on their behalf, may need to obtain, use, or disclose any or all information about my physical and/or mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of (please check or circle):

- Change of Doctor
- Individual request
- Specialist Referral
- Workers Compensation insurance
- Attorney request
- Other: _____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had this document read to me) this authorization, and I agree to its' terms as indicated by my signature below. I am entitled to a copy of this authorization.

_____

Date

_____

Signature of Patient or Patient's Representative

_____

Patient's Representative Relationship, if patient is unavailable to sign