ONE PATIENT PER AUTHORIZATION FORM

Medical Records Request Form

Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. I **UNDERSTAND** that I have the right to revoke this authorization of any time. My revocation must be in writing, signed by me or by my legal representative and delivered to Mend Medical, Inc. My revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this Authorization. I have a right to receive a opy of this Authorization. I will not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.

California law prohibits the requester from making the further disclosure of health information unless the requester obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

AUTHORIZATION: I hereby authorize

Mend Medical, Inc.
4849 Van Nuys Blvd. #100
Sherman Oaks, CA 91403
Phone: (818) 646-4928 Fax: (818) 646-2697

to request and receive medical records and information pertaining to medical history, mental, or physical conditions, for:

_____DOB:_____MR#: _____
(Print last name, first name)

DURATION: This authorization shall become effective immediately and remain in effect for 12 months from the date signed.

SIGNATURE:_____TIME:_____DATE:_____
(Patient/Parent/or Legal Guardian)

Print name:_____Relationship to Patient: _____

Witness:_____Date: _____