LAW OFFICES OF
CHARLES D. NAYLOR

839 South Beacon Street, Suite 311 • San Pedro, California 90731
(310) 514-1200 • (310) 514-1837 fax
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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____
Name of Disclosing Party

_____
Address

_____
City State ZIP

To disclose to The Law Offices of Charles D. Naylor
839 South Beacon Street, Suite 311
San Pedro, California 90731

Records and information pertaining to:

_____
Name Date of Birth

_____
Address Telephone Number

Duration: This authorization shall become effective immediately and shall remain in effect until _____ or for one year from date of signature.
Date

Revocation: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written 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.

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 such use or disclosure is specifically required or permitted by law.

Specify Records:

- ❑ Medical Information _____
- ❑ Drug/Alcohol Information
  _____
  Signature and Date
- ❑ Psychiatric Information
  _____
  Signature and Date
- ❑ Other:

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

The requester may use the health information authorized on this form for the prosecution of my personal injury and/or workers' compensation claim only.

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

Date:_____ Signature: _____