

1. AUTHORIZATION: I authorize disclosure of medical information and health records as described below:
 Name of Patient: _____ Date of Birth: _____
 Social Security Number _____ Telephone: () _____

2. RECORD HOLDER: Name _____
 Address _____

3. RECORDS MAY BE RELEASED TO:
 Robert F. Sterner Jr., M.D.
 1516 W. Redwood St. Ste. 202
 San Diego CA 92101
 619-543-1061/619-543-0043Fax

4. TYPE OF INFORMATION: This authorization does not apply to the following information unless my initial appears beside each applicable category.
 _____ Treatment for alcohol and/or Drug Abuse Treatment
 _____ Psychiatric Records _____ HIV Test Results
 _____ Psychological Tests _____ Psychiatric Evaluation
 _____ Psychiatric Diagnosis _____ Therapy Notes
 _____ Drug Diagnosis _____ Entire Record (Every Page)
 _____ Discharge Summary _____ Progress Notes
 _____ History/Physical _____ Radiology/Nuclear Medicine Reports
 _____ Laboratory Tests _____ Consultation Reports
 _____ Billing Information _____ Emergency Dept. Reports
 _____ Still or Video Images and Sound Prepared for Marketing Purposes
 _____ Operative/Procedure Reports
 _____ Other (Please Specify) _____

5. DATE OF SERVICE: ____/____/____ - ____/____/____

6. USE OF INFORMATION: The individual or entity identified above is permitted to use my information for the following purposes: PLEASE initial all that apply:
 _____ Continuing Medical Care _____ Second Opinion _____ Personal _____ Legal
 _____ Insurance _____ Other (Please Specify) _____

7. DURATION: This authorization is valid for one year from the date next to my signature unless otherwise noted here: _____

8. SIGNATURE:
 Printed Name: _____
 Signature: _____ Date: _____
 If signed by other than patient, indicate relationship to patient _____

 Witness Signature (when applicable): _____
 Attending Physician Signature (Required for Behavioral Health):
 _____ Date: _____

9. MAILING INSTRUCTIONS: DO NOT MAIL THIS FORM TO DR. STERNER. YOU MUST MAIL THIS FORM TO YOUR DOCTOR.