North County Orthopedic Medical Group, Inc.
Sidney H. Levine, M.D.
8929 UNIVERSITY CENTER LANE, SUITE 100
SAN DIEGO, CALIFORNIA 92122-1007
(858) 457-4040 OFFICE (858) 457-4936 FAX
slevine@northcountyomg.com
www.northcountyomg.com

CONSENT TO RELEASE MEDICAL INFORMATION TO SIDNEY H. LEVINE, M.D.

Patient's Name: _____

Date of Birth: _____ **SS#:** _____

Any and all records obtained in the course of my diagnosis and treatment which includes all general medical information, alcohol and/or drug abuse, psychiatric illness, HIV and/or AIDS and/or AIDS-related complex.

This release shall become effective immediately and shall remain in effect for one year from now unless otherwise specified.

This authorization for release of medical information is subject to revocation date. If not revoked, this authorization shall expire as stated on the date noted above. Revocation of this release must be made in writing to: North County Orthopedic Medical Group, Inc.

Purpose of Release:

_____
_____
_____
_____
_____

Signature of Patient: _____ Date: _____

Patient Representative: _____ Date: _____
(Indicate Relationship)