KENNETH ETEFIA, MD

CONSENT TO RELEASE MEDICAL & PSYCHIATRIC INFORMATION

I,

_____

(Patient's Name)

give my consent and authorization to Kenneth Etefia, M.D., to consult with and/or release any medical and/or psychological records to the following provider, hospital, insurance company, attorney, or person. I release Kenneth Etefia, M.D., as well as his employees and agents from any liability arising from the release of this information.

I also give my consent and authorization to the following provider, hospital, insurance company, attorney, or person to consult with and/or release medical and/or psychological records solely to Kenneth Etefia, M.D. I release Kenneth Etefia, M.D., the below named entity, as well as their employees and agents from any liability arising from the release of this information to the office of Kenneth Etefia, M.D.:

_____

_____

_____

(Name and Address of Individual or Institution)

1036 Sir Francis Drake Boulevard
Kentfield CA 94904
P: (415) 361-8065 F: (415) 358-4513

This authorization is valid until _____ or 12 months from the date of this consent form.

This authorization is at my request and strictly for the purpose of:

___ Diagnosis

___ Coordination of care

___ Lab tests

___ Treatment history

___ Insurance

___ Other (explain):

_____

(Purpose of Release)

I may revoke this authorization by writing a letter to Kenneth Etefia, M.D., at any time. Revocation would not affect any actions already taken by Kenneth Etefia, M.D., based upon this authorization. I am entitled to receive a copy of this form.

I understand I do not have to sign this authorization in order to receive medical care.

_____

Patient's or Guardian's Signature Date

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