Pacific
Medical Care

1501 5th Avenue Suite #100

San Diego, California 92101

Office: 619-461-3717 Fax: 619-461-5663

1. Treatment Authorization

I authorized Michael S. Duffy, INC, it's physician's, technician's, and any other designated provider to perform such examinations, treatments, Laboratory tests, osteopathic manipulative treatment, intra-articular joint injections, psychiatry, psychology, wound care and debridement, nail removal, wart and mole removals, administer medications, influenza vaccination (including H1N1) as deemed necessary in his or her opinion. The treatment and or procedure, and any associated risks have been explained to me in detail. I certify that nether guarantee nor assurance has been made about such examinations, treatments, laboratory tests, osteopathic, manipulation treatments, intra-articular joint injections, psychiatry, psychology, wound care and debridement, nail removals, wart and mole removals.

2. Insurance Authorization and Assignment of Benefits

I request that payment of authorization benefits be made to Michael S. Duffy, SR, DO Inc. On my behalf or services rendered. I authorize the release of all necessary medical information to any parties responsible for paying such benefits

3. Release of Medical Records

I agree that a copy of my medical record may be released to my physician or referring provider to ensure proper follow up and continue. I further consent Michael S. Duffy, SR, DO, INC to request my medical records from any provider, hospital, clinic or other health care institution whenever deemed necessary by them providing optional medical services. Such medical records are to be sent to Michael S. Duffy, SR, DO Inc. 1501 5th Avenue Suite 100, San Diego, California 92101 and facsimile number 619-461-5663.

I understand I may revoke this authorization at any time. My revocation must in writing and signed by me or on my behalf and delivered to Michael S. Duffy, SR, DO Inc. unless otherwise noted, this authorization will expire one year from the date of my signature.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPPA). California law prohibits the person receiving my health information from making further disclosure unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

4. Length of Authorization

This authorization shall be in effect from this day signed until terminated in writing by the patient or DPOA

_____ _____

Date Signature of Patient or Authorized Party

_____ _____

Patient's Date of Birth Print Name of Patient or Authorized Party