AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION *FROM* MSM

Completion of this document authorizes the disclosure and/or use of health information about me. Failure to provide all information requested may invalidate this authorization.

Patient Name: _____

Birth Date: _____

I hereby authorize **Main Street Medical** to release to:

_____

(Person or facility authorized to receive the information)

_____

(Address - street, P.O. box, apartment)

_____

(Address - city, state, zip code)

_____

(fax)

the following information:

- ❑ All health information pertaining to my medical history, mental or physical condition, and treatment received; or
- ❑ Only the following records or types of health information (include dates as needed):

_____

_____

_____

I authorize release of the following categories of information **only** when the corresponding box is checked:

- ❑ Mental health treatment information
- ❑ Alcohol and drug abuse treatment information
- ❑ HIV test results
- ❑ Genetic testing information

PURPOSE

Purpose of request, if not initiated by patient:

_____

Limitations, if any: _____

EXPIRATION

Unless otherwise revoked, this authorization expires on _____.
(optional expiration date)

If the expiration date is blank, this authorization expires one (1) year after the signature date.

MY RIGHTS

- I may inspect or obtain a copy of the health information that I am asking to be disclosed.
- I may revoke this authorization at any time, but I must do so in writing and submit it to:
  799 Main Street, Ste D
  Half Moon Bay CA 94019
  My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

_____

(Patient or legal representative)

Date: _____

If signed by a person other than the patient, print name and indicate relationship:

Print Name: _____

Relationship: _____

RECEIVED (Office Use Only)

_____ _____

(Signature) *(Date)*