AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION *TO* 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:

_____

(Person or facility which has information)

to release to **Main Street Medical**
799 Main Street, Ste D
Half Moon Bay CA 94019
650-726-1236 (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 (including 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.
- I have a right to receive a copy of this authorization.
- Main Street Medical (and many other organizations and individuals including physicians, hospitals, and health plans) are required by law to keep my health information confidential.

SIGNATURE

_____

(Patient or legal representative)

Date: _____

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

Print Name: _____

Relationship: _____