AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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

Name of Patient: ______________________________ **Date of Birth:** __________

I hereby authorize Main Street Medical to release to:

____

(Persons/Organizations authorized to receive the information)

____

(Address — street, city, state, zip code, fax number)

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 any dates):

____

____

____

I specifically authorize release of the following information (check and initial as appropriate):

❑ Mental health treatment information *Initial*__________

❑ HIV test results *Initial*__________

❑ Alcohol/drug treatment information *Initial*__________

PURPOSE

Purpose of requested use or disclosure:

❑ Patient request, or

❑ Other: ____

Limitations, if any: ____

EXPIRATION

This authorization expires one (1) year after the execution date, or on this date: __________

(optional date)

MY RIGHTS

- I may inspect or obtain a copy of the health information that I am asking to allow the disclosure or use of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to:
  799 Main Street, Suite 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

____ Date: ____________

(patient/legal representative)

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

Print Name: ____ Relationship: ____________