

424 28th Street
Oakland, CA-94609
510-452-4824

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize

Name of Disclosing Party -

Address

City State Zip Code

to disclose to

Name of Recipient

Address

City State Zip Code

records and information pertaining to

Name of Patient Birth Date

Address Phone Number

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____

Revocation: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party, or others have acted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify records: Medical records. Drug/Alcohol Abuse. Mental Health Records *HN* results
Other health information: _____

I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.