Authorization for Use and/or Disclosure of Medical Information

HealthCare™ PARTNERS MEDICAL GROUP

Treatment, payment, enrollment or eligibility benefits will not be conditioned on my providing or refusing to provide this authorization. I hereby authorize the physicians and/or employees of _____ to release information as indicated below.

Release records and information regarding:

Patient Name: _____ DOB: _____

Address: _____ SSN: _____

_____ Tel: _____

Release information to:

_____
Name of Receiving Party

_____
Address

_____
City, State, Zip Code

_____
Telephone #

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.

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

SPECIFY RECORDS: Check the box and initial and date which type of information is to be disclosed:

- ❑ Health Information Record _____
- ❑ Psychiatric Record _____
- ❑ Drug/Alcohol _____
- ❑ HIV Test Results _____
- ❑ Other (Specify) _____

I request that the health information released pursuant to this authorization be used for the following purposes only:

_____

_____

A copy of this authorization is valid as an original.

I have received a copy of this authorization, _____ (initial)

_____
Date

_____
Signature of Patient of Patient's Representative

_____
Indicate Relationship (if signed by other than Patient)