AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I understand that completion of this form means that I am giving permission for the use and disclosure described below.

Please carefully review and complete this form. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purpose for the disclosure.

I hereby authorize: ALLERGY AND ASTHMA ASSOCIATES OF NORTHERN CALIFORNIA

☐ San Jose, Gilroy & Mountain View Office's	☐ Fremont Office	☐ Santa Cruz Office	☐ Monterey Office
4050 Moorpark Ave.	2287 Mowry Ave., Ste E	3329 Mission Drive	337 El Dorado Street
San Jose, CA 95117	Fremont, CA 94538	Santa Cruz, CA 95065	Suite 2A
Fax: (408) 984-1594	Fax: (510) 797-5596	Fax: (831) 479-6940	Monterey, CA 93940
			Fax: (831) 649-6340

To disclose to: _____

Name of Recipient

_____

Address

_____

City **State** **Zip**

Records and information pertaining to:

_____ _____

Name or Patient (List Other Names Used) Date of Birth

_____ _____

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 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

General Medical Records- Will be limited to two years of information including lab & X-rays unless otherwise requested.

A fee of $15.00 & $.15c per page must be paid before delivery of medical records to Self/Other.

Check the box and initial to specify which type of information is to be disclosed.

☐ **Complete Medical Records** **Initial:** _____
☐ **Reports and Test Results**
☐ **Medication**
☐ **X-Ray Test Results**
☐ **Lab Test Results**
☐ **Other:** _____
_____
_____

The recipient may use the health information authorized on this form from the following:

_____
_____
_____

Date: _____ **Signature:** _____

If signed by other than patient, indicate relationship: _____