



**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 &
San Mateo Offices**
4050 Moorpark Ave.
San Jose, CA 95117
Fax: (408) 984-1594

☐ **Fremont Office**
2287 Mowry Ave., Ste E
Fremont, CA 94538
Fax: (510) 797-5596

☐ **Santa Cruz Office**
3329 Mission Drive
Santa Cruz, CA 95065
Fax: (831) 479-6940

☐ **Monterey Office**
337 El Dorado Street
Suite 2A
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.

REDISCLASURE: 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: _____