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.

I hereby authorize: _____

Name of Disclosing Party

_____

Complete Address or Fax Number

To disclose to: **ALLERGY AND ASTHMA ASSOCIATES OF NORTHERN CALIFORNIA**

☐ San Jose, Gilroy & San Mateo Offices	☐ 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

Records and information pertaining to:

_____	_____	_____
Name	**Date of Birth**	**Phone Number**

This Authorization shall become effective immediately and shall remain in effect for the **duration** of one year from the date of signature unless a different date is specified here _____.

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.

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.

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

☐ Allergy Testing
☐ Labs & X-Ray's
☐ Other: (Specify the records to be disclosed:

_____
_____
_____

The recipient may use the health information authorized for the following:

_____
_____

Date: _____ Signature: _____

If signed by other than the patient, indicate relationship: _____