

FOSTER CITY PEDIATRIC MEDICAL GROUP, INC.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

THIS AUTHORIZATION IS FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION PERTAINING TO:

Patient's Name: Last: _____ First: _____ MI: _____

DOB: _____ Phone Number: _____ MRN: _____

I HEREBY AUTHORIZE : Name: _____

Address: _____

City, State, Zip: _____

**TO DISCLOSE HEALTH INFORMATION TO: FOSTER CITY PEDIATRIC MEDICAL GROUP, INC.
1295 E. HILLSDALE BLVD.
FOSTER CITY, CA 94404
PH: 650-574-2774 FAX: 650-341-9236**

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:

Medical Records

A specific authorization is required to disclose information regarding the following:

<input type="checkbox"/> Psychiatric/Mental Health	Signature _____
<input type="checkbox"/> Drug/Alcohol Abuse	Signature _____
<input type="checkbox"/> HIV Lab Test Result	Signature _____
<input type="checkbox"/> Genetic /Fertility	Signature _____
<input type="checkbox"/> Other Health Information	Signature _____
<input type="checkbox"/> (Specify _____)	

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

(For example: ongoing medical care or follow up)

- I may refuse to sign and my refusal will not affect my ability to obtain treatment
- The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless the use or disclosure is specifically permitted by law.
- This authorization shall become effective immediately and shall remain in effect until _____. (If no date is given, authorization is valid for 6 months only from signature date).
- I reserve the right to withdraw or revoke this authorization, in writing, at any time, except to the extent that the entity has already disclosed the information.

I understand that I have a right to receive a copy of this authorization.

SIGNATURE _____ **DATE:** _____

If signed by other than patient, indicate relationship: _____