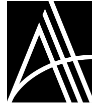


AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I understand that completion of this form means that I am giving permission for the uses 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 purposes for the disclosure.

I hereby authorize: ALLERGY AND ASTHMA ASSOCIATES OF NORTHERN CALIFORNIA

☐ San Jose, Gilroy & Mountain View Office's
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

To disclose to: ______________________________
Name of Recipient

____
Address

____
City State Zip

Records and information pertaining to:

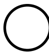
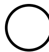
______________________________ ______________
Name of Patient (List Other Names Used) Date of Birth

______________________________ ______________
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 & $.15 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.

- ☐ General Medical Information: _______ Initial
- ☐ Results of an HIV Blood Test:

  ____________________________ Signature   ______________ Date

- ☐ Other Health Information: _______ Initial (Specify Below)

Specify the records to be disclosed:

____
____
____

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

____
____
____

Date: _______________ Signature: ____

If signed by other than patient, indicate relationship: ________________________