SOUTH VALLEY MULTI-SPECIALTY MEDICAL GROUP

173 N MORRISON AVE. SUITE C
SAN JOSE, CA 95126

TINO GALLO, MD
NORMAN LOWENBRAUN, MD
408-293-1992

AUITHORIZATION TO OBTAIN OR RELESE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMEBERS

In accordance with the Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of South Valley Multi-Specialty Medical Group, Inc. to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

______ I authorize South Valley Multi-Specialty Medical Group, Inc. to verbally release any and all information concerning my medical care to the following individuals.

____ ________________________
Name Relationship to Patient

____ ________________________
Name Relationship to Patient

____ ________________________
Name Relationship to Patient

____ ________________________
Name Relationship to Patient

____ ________________________
Name Relationship to Patient

______ I authorize South Valley Multi-Specialty Medical Group, Inc. to leave messages regarding my medical care or appointments on my answering machine/voice mail.

____ ________________________
Patient Signature Date