South Valley Multi-Specialty Medical Group
173 N Morrison Ave. Suite C
San Jose, CA 95126

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I hereby authorize ____

Name of Disclosing Party

____

Address

____

City State Zip

to disclose to ____

Name of Recipient

____

Address

____

City State Zip

records and information pertaining to

____

Patient Last Name First Date of Birth

____

Address Telephone Number

____

Other Names Used Medical Record Number

Duration: This authorization shall become effective immediately and shall remain in effect for one year from date of signature unless a different date is specified here__________________.

Revocation: This authorization is also subject to written revocation by the patient ant 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 this 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 permited by law.

Specify Records

Initial to specify which type of information is to be disclosed:

Progress Notes ______________
Laboratory and X-ray Reports______________
Pathology Report______________
Psychiatric Records______________
Send Entire File______________
Immunization Booklet ______________
Copy of Radiology Films______________
Pathology Slides ______________
Alcohol & Drug Abuse Record______________
Other (Specify below)* ______________

*Specify other records to be disclosed ____
____
____

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

Date:__________________________________ Signature: ____