

East Bay Perinatal Medical Associates

Authorization For Use Or Disclosure Of Health Information

Completion of this document authorizes the disclosure and/or use of your health information. Failure to provide all information requested may invalidate this authorization.

Name of Patient: _____ Date of Birth: _____ Today's Date _____

I. USE AND DISCLOSURE OF HEALTH INFORMATION: I hereby authorize,

Person/ or Organization _____

Address _____ Phone/ Fax Number _____

to release to East Bay Perinatal Medical Associates, to the following location...

- | | | |
|---|----------------|----------------|
| <input type="checkbox"/> 350 30 th Street, Suite 208, Oakland, CA, 94609 | (510) 444-0790 | (510) 869-6225 |
| <input type="checkbox"/> 5730 Telegraph Ave., Suite 117, Oakland, CA 94609 | (510) 204-1507 | (510) 601-7092 |
| <input type="checkbox"/> 9260 Alcosta Blvd. Suite 17A, Bldg. C, San Ramon, CA 94583 | (925) 803-2222 | (925) 803-2223 |
| <input type="checkbox"/> 2191 Mowry Ave., Suite 500-E, Fremont, CA 94538 | (510) 794-4790 | (510) 794-4601 |
| <input type="checkbox"/> 2648 International Blvd., 7 th Floor, Oakland, CA 94601 | (510) 437-8060 | (510) 437-8064 |
| <input type="checkbox"/> 3232 Elm St. Suite B, Oakland, CA 94609 | (510) 652-8881 | (510) 419-4915 |

OR

I hereby authorize, East Bay Perinatal Medical Associates to release to:

Person/or Organization _____

Address _____ Phone/Fax Number _____

...the following information:

- All health information pertaining to my medical history, mental or physical condition, and treatment received.
- Only the following records or types of health information (including any dates):

OR

I specifically authorize release of the following information (check as appropriate):

- Mental health treatment information
- HIV test results
- Alcohol/drug treatment information

NOTE: A separate authorization is required to authorize the disclosure or psychotherapy notes.

Name of Patient: _____ Date of Birth: _____

(Continued)

2. PURPOSE

The purpose of the requested use or disclosure:

- Patient request
- Other (please specify): _____

3. EXPIRATION

This Authorization shall become effective immediately and shall remain in effect for 1 year from the date of signature unless a different date is specified here: [insert date]: _____

4. RESTRICTIONS

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

5. YOUR RIGHTS

- ✓ I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- ✓ I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- ✓ I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: _____

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

- ✓ I have a right to receive a copy of this authorization.

6. SIGNATURE

Signature: _____
(Patient/representative/spouse/financially responsible party)

Date: _____ Time: _____ AM/PM

NOTE: If this document is signed by someone other than the patient, please indicate your legal relationship to the patient:

Signature of witness: _____