Pacific Family Practice Medical Group

A Professional Corporation

Authorization for Use and/or Disclosure of Patient Health Information:

I Authorize:

_____

Name of disclosing party

_____

Address

_____

City Sate Zip

To disclose records to:
Pacific Family Practice Medical Group
1 Shrader St., Suite 578
San Francisco Ca, 94117
P: 415-876-5762
F: 415-876-4538

Records and Information Pertaining To:

Patients Name: _____

Last First MI

Patients Date of Birth: _____/_____/_____

(mm/dd/yyyy)

Home Address: _____

Street City Sate/Zip

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

Revocation: This authorization is also subject to written revocation by the patient at any time. This written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization

Re-disclosure: 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: check the box to specify which type of information is to be disclosed, then sign and date your selection:

	Signature	Date
☐ Medical Information	_____	_____
☐ Psychiatric Information	_____	_____
☐ Drug/ Alcohol Information	_____	_____
☐ HIV/AIDS Test/ Treatment	_____	_____
☐ Other Health Information:	_____	_____

_____

(Specify records to disclose)

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

_____

A copy of this authorization is as valid as the original. Patient has a right to a copy of this authorization

_____ _____ _____

Date Signature Relationship