FOSTER CITY PEDIATRIC MEDICAL GROUP, INC.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

THIS AUTHORIZATION IS FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION PERTAINING TO:

Patient's Name: Last: _____ First: _____ MI: _____

DOB: _____ Phone Number: _____ MRN: _____

I HEREBY AUTHORIZE: Name: _____

Address: _____

City, State, Zip: _____

TO DISCLOSE HEALTH INFORMATION TO: **FOSTER CITY PEDIATRIC MEDICAL GROUP, INC.**
1295 E. HILLSDALE BLVD.
FOSTER CITY, CA. 94404
PH: 650-574-2774
FAX: 650-341-9236

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:

___ Medical Records

A specific authorization is required to disclose information regarding the following:

___ Psychiatric/Mental Health
___ Drug/ Alcohol Abuse
___ HIV Lab Test Result
___ Genetic / Fertility
___ Other Health Information
(Specify_____)

Signature _____
Signature _____
Signature _____
Signature _____
Signature _____

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

_____

(For Example: ongoing medical care or follow up)

- I may refuse to sign and my refusal will not affect my ability to obtain treatment
- The recipient may not lawfully further or disclose the health information unless another authorization is obtained from me or unless the use or disclosure is specifically permitted by law
- This authorization shall become effective immediately and shall remain in effect until _____. (If no date is given, authorization is valid for 6 months only from signature date)
- I reserve the right to withdraw or revoke this authorization, in writing, at any time, except to the extent that the entity has already disclosed the information.

I understand that I have the right to receive a copy of this authorization.

SIGNATURE _____ DATE: _____

If signed by other than the patient, indicate relationship: _____