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: _________________________DOB: ____________ MRN:______________

Patient's Name: Last: ____________________ First: _________________________DOB: ____________ MRN:______________

Patient's Name: Last: ____________________ First: _________________________DOB: ____________ MRN:______________

I HEREBY AUTHORIZE:

Name of Facility: ____

Address: ____

Phone Number _________________________________ Fax Number ____

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 ___ Psychiatric/Mental Health___ Drug/ Alcohol Abuse___ HIV Lab Test Result ___Genetic / Fertility

___Other Health Information Specify____

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: ____