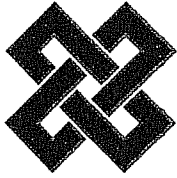


Northern California Medical Associates, Inc.
Authorization for Release of Protected Health Information

Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.



NORTHERN
CALIFORNIA
MEDICAL
ASSOCIATES

1. To be completed by the patient or the patient's authorized representative:

_____		_____
Patient's Name		Date of Birth
_____		_____
Street Address		Telephone
_____	_____	_____
City	State	Zip Code

2. I hereby authorize:

Northern California Medical Associates, Inc., or

Other physician or provider (please specify):

3. To release my confidential health information, as described below, to:

Myself or my authorized representative
(please specify representative): _____

Northern California Medical Associates, Inc.
(please specify location): _____

Other:

_____	_____	
Name	Telephone Number	

Organization		

Street Address		
_____	_____	_____
City	State	Zip Code

4. In the following manner:

Copies by mail

Inspection

Copies by fax

Other: _____

Copies to be picked-up

- CONTINUED ON OTHER SIDE -

Patient's Name (please print)

5. The health information being released may be used for the following purpose(s) only:

6. My authorization is for the use and disclosure of the following records (please initial):

- Any and all medical records
- AIDS (Acquired Immunodeficiency Syndrome), HIV (Human Immunodeficiency Virus) information, or other sexually transmitted disease
- Substance abuse and/or rehabilitation records
- Mental health records
- X-Rays

Information that is disclosed under this authorization may not lawfully be disclosed again by the person or organization to which it is sent unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. The privacy of this information may not be protected under federal privacy regulations.

This authorization shall be effective immediately and shall remain in effect until _____ or for one year from the date of signature. This authorization may be revoked in writing at any time. My written revocation will be effective upon receipt but will not be effective to the extent that Northern California Medical Associates, Inc. or others have acted in reliance upon this authorization. I understand that I may request a copy of this signed authorization.

Signature of Patient

Date

Signature of Parent or Personal Representative

Date

Name of Parent or Personal Representative (please print)

Telephone

Description of Legal Authority to Act on Behalf of Patient