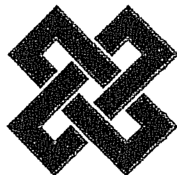
Northern California Medical Associates, Inc.
Authorization for Release of Protected Health Information

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., <u>or</u>

☐ 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