Shilpi Anand, M.D.
Karna Gendo, M.D.
Katherine Gilbert, M.D.
Joshua Jacobs, M.D.
Valerie Jerdee, M.D.
Ilisten Jones, M.D.
Barbara Karpel, MD.
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ALLERGY & ASTHMA
MEDICAL GROUP OF THE BAY AREA

Fannie Su, M.D.
Allyson Tevrizian, M.D.
Whitney Block, N.P.
Lima Cranford, N.P.
Agnieszka Danielewicz, P.A.
Tina Dominguez, P.A.
Angela Ingram, N.P.
Tara Mostofi, P.A.-C
Amy Shell, N.P.

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

Patient Name:_____ **DOB:**_____
Last **First** **Initial**

I hereby authorize	to disclose to
Name of Person/Organization Providing the Information:	Person/Organization to Receive Information:
Address	Address:
City, State and Zip Code	City, State and Zip Code
Phone / Fax #:	Phone / Fax #:

The information to be released or used includes:

____Complete Medical Record
____Other:_____
____ X-ray Test Results
____ Reports and Test Results
____ Lab Test Results
____ Medication

Dates to be included in this release:

____ No date restriction/all dates ____ From_____to_____

The type of information to be disclosed includes:

____Medical Information Only
____Psychiatric/Mental Health Information _____
Sign and Date
___ Results of an HIV Blood Test _____
Sign and Date

Complete this section when releasing Patient Health Information.

Completed Date ___/___/___ Initials:_____ ___Faxed ___ Mailed ___ Picked up
___Other:_____

OVER

This authorization will automatically expire one (1) year from the date signed or on:

_____.

Specify date or event

This information will be used for

☐ Patient Care

I understand:

- I may refuse to sign this authorization. Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.
- I may inspect or obtain a copy of the medical information covered by this authorization.
- I understand that there is a fee to obtain copies of medical records except when copies are sent directly to a physician or health care provider.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to Allergy & Asthma Medical Group of the Bay Area, Inc. My revocation will be effective upon receipt, except where use or disclosure has already occurred in accordance with this Authorization.
- I have a right to receive a copy of this Authorization upon my request.
- If disclosure of this health information is to someone who is not legally required to keep it confidential, it may be redisclosed and may be no longer protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

Signature:_____ Date:_____

Patient or Personal Representative (Parent/Legal Guardian)

Print Name:_____ _____ Phone #:_____

Address:_____

If Personal Representative, state relationship:_____