women's specialty center
OBSTETRICS & GYNECOLOGY
A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP & A PART OF SANTÉ HEALTH FOUNDATION

722 Medical Center Drive, East #101
Clovis, California 93611
Telephone: (559) 297-9500
Facsimile: (559) 297-9572

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I hereby authorize _____
NAME OF DISCLOSING PARTY

_____
ADDRESS

CITY STATE ZIP CODE

To disclose to _____
NAME OF RECEIVING PARTY PHONE # EXT.

_____
ADDRESS

_____
CITY STATE ZIP CODE

Records and information pertaining to:

_____ _____ _____
NAME OF PATIENT (LIST OTHER NAMES USED) SOCIAL SECURITY # DATE OF BIRTH

_____ _____
ADDRESS CITY STATE ZIP CODE PHONE #

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature.

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester of others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY: Check the box and initial to specify which type of information is to be disclosed.

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RECORDS: □ MEDICAL INFORMATION _____
INITIAL

□ RESULTS OF AN HIV BLOOD TEST _____ _____
SIGNATURE DATE

□ OTHER HEALTH INFORMATION _____ (specify below)

Specify the records to be disclosed: _____

_____

_____

_____

The requester may use the health information authorized on this form for the following purposes only: _____

_____

_____

Signature:_____ Date:_____