John Muir / Mt. Diablo Health System

John Muir Family and Immediate Care 1455 Montego #205 Walnut Creek, Ca 94598

AUTHORIZATION FOR USE AND/OR Phone: (925) 939-4444 Fax: (925) 939-5010 DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information, about you Failure to provide *all* information requested may invalidate this Authorization.

I hereby auto release to					
to release to	<i>.</i>				
	rganizations au	thorized to <i>receive</i> the information) (A	(Address-street, city, state, zip code)		
Yes No	Date		Dates:		
	All records	From	TO		
	☐ Mental l☐ HIV test	records, please specify which records realth treatment information results cohol treatment information	s are to be withheld		
<u>OR</u>			Dates:		
Yes No)	From	TO		
	•	Only those records pertaining to specific medical data (ie Motor Vehicle accident, immunizations, etc.)			
Specify: _					
		•			

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

<u>Please Note:</u> In the event that this office is contacted by your Life/Health/Disability insurance company to release your medical record, you are forfeiting, the confidentiality of your Protected Health Information (PHI).

The insurance company's interpretation of your health may not always coincide with your physicians' opinion of your overall medical health, which may adversely affect your insurance coverage.

PURPOSE		
Purpose of requested use or disclosure: personal fi OR other: (please specify purpose below)	les changing providers m	noving
EXPIRATION		
This authorization will expire 30 days from the date si	gned unless otherwise stated.	
Expiration Date		
My RIGHTS		
I may refuse to sign this Authorization. My refusal will not affe eligibility for benefits. However, my refusal may hinder the rele		yment or
I may inspect or obtain a copy of the health information that I a	m begin asked to allow the use or disc	losure of.
I have a right to receive a copy of this authorization.		
I may revoke this authorization at any time, but I must do so in this authorization was originally submitted.	writing and submit it to the office addr	ress where
My revocation will take effect upon receipt, except to the extendathorization.	t that others have acted in reliance upo	n this
Information disclosed pursuant to this authorization could be re in some cases not protected by California law and may no longe (HIPAA).	• •	
SIGNATURE		
Date: Phone Number:	Time:	_am/pm
Printed Name:	_ Date of Birth:	
Signature:		
Signature:	onsible party)	
If signed by someone other than the patient, state your	legal relationship to the patient:	