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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards

PATIENT NAME: _____

DOB: _____

I hereby authorize:

Physician Name:

_____

Address: _____

Tel: _____

Fax: _____

To release to the following recipient:

Physician Name:
Dr. Nicole Vecchi

Address: 429 S. Main St, Milpitas, CA 95035

Tel: (408) 935 - 9586

Fax: (408) 719 - 1979

TO USE OR DISCLOSE THE FOLLOWING HEALTH INFORMATION CHECKED BELOW:

- ☐ All of my health information
- ☐ My health information relating to the following treatment or condition:
  _____
- ☐ My health information covering the period from _____ (date) to _____ (date)
- ☐ Other: _____

This authorization ends:

- ☐ 6 months from the date of signature
- ☐ On (date): _____

My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses of disclosures have already been made based upon original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with y permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Patient Signature: _____ Date: _____