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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 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 or 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 my 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: \_\_\_\_\_

**To release to the following recipient:**

Physician Name:

**NONG DANG MD**

Address: 2365 QUIMBY RD, SUIT 220, SAN JOSE, CA 95122

Tel: 408-550-2981

Fax: 408-719-1979