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(510) 848-7977
(510) 848-2831 FAX

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

To: _____

_____

_____

I hereby authorize you to release my Protected Health Information (PHI) to:

Drs. Klebanoff, O'Melveny, Drinkard, & Bodor
3000 Colby St., Ste. 200
Berkeley, CA 94705
(510) 848-7977; (510) 848-2831 FAX

IF RECORDS ARE MORE THAN 15 PAGES, PLEASE MAIL

☐ I authorize the disclosure of my **ENTIRE PHI.**

OR

I authorize the disclosure of the following services:

☐ Provider Notes ☐ Radiology Reports ☐ Discharge Summary ☐ Lab(s) Reports
☐ Hospital Records ☐ Pathology Reports ☐ Operative/Procedure Notes ☐ Imaging Reports
☐ Infusion Records ☐ HIV results/testing ☐ Other (specify): _____

rendered to me during the period from _____ to _____.

For the following purpose:
☐ Continuing Medical Care ☐ Legal
☐ At the request of the patient ☐ Insurance ☐ Other: _____

- I understand that Drs. Klebanoff, O'Melveny, Drinkard, and Bodor will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization form, except in the following situations:
  - IF the medical information to be disclosed will result from treatment or research purposes, Drs. Klebanoff, O'Melveny, Drinkard, and Bodor will not provide the treatment if I am unwilling to sign this authorization form.
  - IF the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, Drs. Klebanoff, O'Melveny, Drinkard, and Bodor will not provide treatment if I am unwilling to sign this authorization form.
- I understand that I may revoke this authorization by sending a ***written request*** for revocation to Drs. Klebanoff, O'Melveny, Drinkard, and Bodor. If I revoke this authorization, Drs. Klebanoff, O'Melveny, Drinkard, and Bodor will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when Drs. Klebanoff, O'Melveny, Drinkard, and Bodor discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the receipt of information.
- I understand that there may be a fee associated with the release of my medical information.
- I understand that this authorization will expire 12 months from the date signed unless I indicate otherwise here _____

Signature: _____ Date Signed: _____

Relationship to patient: _____

Reason patient unable to sign:
☐ Minor ☐ Deceased ☐ Other: _____
(Please specify and provide legal documentation if needed)