Palo Alto Medical Foundation
A Sutter Health Affiliate

Palo Alto Medical Clinic, 795 El Camino Real, Palo Alto, CA 94301
(650) 853-4745, (650) 853-6093 Fax

MUST COMPLETE FORM IN ORDER TO AVOID ANY DELAYS PAMF # ____________

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This authorizatioin for use or disclosure of my health information is required by state and federal law.

PATIENT'S NAME ____________ (Last) ____________ (First) ____ (MI) DOB: ____________

Daytime Telephone Number ____________ Social Security No.: ____________

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY HEALTH INFORMATION

Palo Alto Medical Foundation
(NAME OF PERSON OR ORGANIZATION RELEASING INFORMATION)
795 El Camino Real
STREET ADDRESS
Palo Alto — CITY; CA — STATE; 94301 — ZIP CODE

TO RELEASE MY HEALTH INFORMATION TO:

____
(NAME OF PERSON OR ORGANIZATION RECEIVING INFORMATION)
____
STREET ADDRESS
____
CITY ____ STATE ____ ZIP CODE ____

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION

☐ All records ☐ Lab ☐ Imaging reports ☐ Immunizations
☐ Other ____________

THE RECIPIENT MAY USE MY HEALTH INFORMATION ONLY FOR THE FOLLOWING PURPOSE

____
(PLEASE SPECIFY)

A SPECIFIC AUTHORIZATION IS REQUIRED TO RELEASE INFORMATION REGARDING THE FOLLOWING:

*Important: Please check the "yes" or "no" box, then initial at the Xs.		YES	NO	INITIALS
	HIV Information	☐	☐	X ____
	Drug/Alcohol Information	☐	☐	X ____
	Mental Health Information	☐	☐	X ____

Restrictions: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recepients outside the state of California.

This authorization shall be valid until X ____________. Please indicate a date after which no information can be released. If no date is given, authorization is valid for 90 days only.

I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment.
I may revoke this authorization at any time, in writing. The revocation must be signed by me or on my behalf and sent to the address on the top of this form. The revocation is effective upon receipt but will have no impact on uses or disclosure made while the authorization was valid.

I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION. Copy Requested: ☐ Yes ☐ No Copy Received: ☐ Yes ☐ No

Patient Signature X ____________ Date X ____________

Patient/Personal Representative Signature ____________

Relationship to Patient ____________

DISTRIBUTION: White – Record; Yellow – Copy

FORM 143444 (December 2003)