TENTH STREET PEDIATRIC MEDICAL GROUP, INC.

1450 Tenth Street, Suite 304 * Santa Monica, CA 90401-2838
Phone (310) 458-1714 * Fax (310) 394-8754

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION FOR PATIENTS 18 YEARS AND OLDER

TO: Tenth Street Pediatrics

Patient's Name: _____

Patient's date of birth: _____

Patient's cell phone: _____

Patient's email address: _____

☐ I **do not** give my permission to discuss my medical history with anyone.

☐ I voluntarily authorize and direct Tenth Street Pediatrics to disclose my health information during the term of this Authorization to the recipient that I have identified below:

Name: _____

Address: _____

_____

Phone: _____

I understand that I have the right to limit the type of information released from my medical records, as in the case of HIV test results, mental health information, and alcohol and drug abuse information. The following information is to be released:

☐ *I have no limitations on the information to be released from my medical record, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that Tenth Street Pediatrics may hold.*

☐ *The information to be released from my medical records shall be limited to:*

_____ *Last physical exam visit on:* _____

_____ *Last sick visit on:* _____

_____ *Lab results*

_____ *Medical treatment plan*

_____ *Radiology*

_____ *Prescription*

_____ *Referral to:* _____

_____ *Other:* _____

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Redisclosure
I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke
I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal ore revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation
I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions
I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have the right to receive a copy of this Authorization from my health care provider.

Photocopy
A photocopy, fax or electronic copy of this Authorization shall be considered as effective and as valid as the original.

Term
This Authorization will remain in effect for one (1) year from the date this Authorization is signed.

Signature	Date	Signature of Witness

Name (please print)

If Individual is unable to sign this Authorization, please complete the information below.

Signature of Personal Representative	Date	Signature of Witness

Name (please print)	Legal Relationship