AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: ______________________________ Date of Birth: ____________

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Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of his Authorization to the recipient that I have identified below.

Name of Provider: ______________________________ Fax: ____________

Address of Provider: ______________________________

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Recipient and Address for Delivery of Records:

Valley Pediatric Medical Group, INC.
5353 Balboa Boulevard, Suite 104
Encino, CA 91316

Ph: 818-789-7181
Fax: 818-986-8322

Purpose: I understand that the specific purpose of this Authorization is

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

O All of my health information that the provider has in his or her possession, 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 the above-named health care provicer may hold.

O All of my health information described above except for the following:

O Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)

<u>**Term:**</u> This Authorization will remain in effect for one (1) year from the date this authorization is signed.

Redisclosure: I understand that once my health care provider discloses my health information to 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 or 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 reciept 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 the provider 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 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.

______________________________ ______________ ______________________________

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 | Legal Relationship | Date | Witness Signature