san mateo RHEUMATOLOGY, INC

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Authorization For Use or Disclosure of Protected Health Information

Janeen Thompson, Privacy Officer (650) 348-6011

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and updated May 10, 2016 and pursuant to California Law, this Practice may not use or disclose your individually identifiable Protected Health Information (PHI) except as provided in our Notice of Privacy Practices without your authorization

This form allows you to provide us with authorization to disclose your Protected Health Information (PHI) to persons that you designate to have access to your PHI, such as family members and caregivers.

Please specify names of people whom we *can* release your medical information (other than the parties noted above in our Notice of Privacy Practices) such as family members, neighbors, etc.

In simple terms – Who do you give us permission to speak with concerning your health?

Name *Relationship*

_____

_____

_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

This authorization is effective now and will remain in effect until 10 years from the date below. I understand I have a right to receive a copy of this authorization.

Signed:_____**Dated:**_____

Print Name:_____**D.O.B.:**_____

Address:_____

If not signed by the patient, please indicate relationship: ___ Parent or guardian of minor child
___ Guardian or conservator of an incompetent person ___ Beneficiary or personal representative of a deceased patient

Treating MD signature:_____Dated:_____

Effect of Refusal to Sign Authorization:
I understand that my health care treatment or benefits will *not* be affected whether I sign or do not sign this form.