Peninsula Gastroenterology Medical Group

2900 Whipple Ave., Suite 245
Redwood City, CA 94062
(650) 365-3700

Fax (650) 368-3836

2500 Hospital Dr., Bldg. 8, Ste. B
Mountain View, CA 94040
(650) 964-3636

Authorization for Use or Disclosure of Protected Health Information

A. Explanation

In order to receive or release medical information, we must comply with the terms of the Confidentiality of Medical Information Act of 1891, Section 56, of the California Civil Code and the Health Information Portability and Accountability Act of 1996 (HIPPA). We are required to obtain your written authorization with this document.

B. Authorization

I hereby authorize _____

_____

To furnish to Peninsula Gastroenterology Medical Group
2900 Whipple Ave., Suite 245, Redwood City, CA 94062

Medical records and information pertaining to medical history, mental or physical condition, services rendered, or treatment for:

_____	_____	_____
Name of Patient	SSN	Date of Birth

C. I understand that I have the right to limit the type of information to be released. I have indicated below the information which is authorized for release: *

☐ All medical information, WITHOUT EXCEPTION

☐ All medical information EXCEPT: _____

☐ **Information regarding HIV testing (and/or lab results, psychological, or psychiatric treatment, and drug or alcohol abuse)**
Requires specific consent: (Signature)_____

☐ The following information only: _____

* If boxes are not checked, we will assume disclosure of all medical records without exception

D. Duration

This authorization shall become effective immediately and shall remain in effect until _____

E. Restrictions

I understand that the recipient may not use or disclose the medical information further, unless another authorization is obtained from me or unless such use or disclosure is specifically required by law.
(We reserve the right to charge for copies of medical records.)

G. SIGNATURE

Signed: _____ Date: _____
(Patient, Parent, Guardian or Legal Representative of Patient)
If signed by someone other than patient, indicate relationship **: _____
Witness: _____

** Authorized representative must submit copies of legal documents supporting assignment of this authority.