

Jon M. Scott D.O. 1150 Scott Blvd., St. D-1 Dr Santa Clara, CA 95050

Authorization for release and or disclosure of protected health information

Please **REQUEST** medical information **From:**

Please **SEND** Medical Information **To:**

Name of doctor, Clinic, or Hospital

Address

City, State, ZIP

Phone Number

Fax Number

Dr. Jon M. Scott D.O.
1150 Scott Blvd., Suite D1
Santa Clara, CA 95050
Phone (408) 246-9915
Fax (408) 246-0187

I hereby authorize _____ to release and/or disclose the protected health information as indicated below to the health care provider, entity or person I have indicted above.

Release and/or disclose records and information regarding:

Patient Name: _____ Date of Birth: _____

Address _____ City/State/ZIP Code: _____

Daytime Phone #: _____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____(Date)

REVOCAION: This authorization may be revoked in writing by the undersigned at anything prior to he release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before written revocation was received.

RE DISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless is specifically required or permitted by law.

SPECIFY RECORD TO BE RELEASED AND/OR DISCLOSED:

General Medical Information (From _____ To _____)

Diagnosis: _____

Other:(Specify): _____

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only: _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.

Date

Signature of patient/legally responsible party

Relationship to patient if not patient