Healthy Start Pediatrics
525 South Drive, Suite 201, Mountain View, CA 94040
Phone: (650) 968-8891 | Fax: (650) 968-8822
www.healthystartped.com

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

(*Fill out both completely, Print all information clearly*)

Name:_____ Date of Birth: _____
Last *First* *Middle*

I voluntarily authorize and direct the health care provider names immediately below ("Provider") to disclose my health information during the terms of this Authorization to the recipient ("Recipient") that I have identified in the next section.

Provider:_____

Address of Provider: _____

_____

Office Phone Number:_____ Office Fax Number: _____

Recipient and Address for Delivery of Records:

Recipient: _____

Address of Recipient: _____

Office Phone Number:_____ Office Fax Number: _____

Purpose: The specific purpose of this Authorization is:

_____

Information to be disclosed: This authorization permits Provider to disclose the following medical records:

☐ All of my health information that 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, correspondence, and records from my other health care providers that Provider may hold.

☐ All of my health information described in the last para except for the following:

_____

Healthy Start Pediatrics
525 South Drive, Suite 201, Mountain View, CA 94040
Phone: (650) 968-8891 | Fax: (650) 968-8822
www.healthystartped.com

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

_____

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

Re-disclosure: It is my responsibility to verify that Recipient abides by applicable federal and state law governing the use and disclosure of my health information. I understand that once Provider discloses my health information to Recipient, Provider cannot guarantee that Recipient will not re-disclose my health information to a third party. This third party may not be required to abide by applicable federal or state law governing the use or 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 Provider at Provider's regular office address. The revocation will be effective immediately upon Provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by Provider in reliance on this Authorization before Provider received my written notice of revocation.

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

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

_____ _____ _____
Signature *Date* *Signature of Witness*

Name: _____

*If Individual is unable or unauthorized to sign this Authorization, please complete the information below. It is the Individual's or Representative's responsibility to obtain any and all necessary permissions before signing.

_____ _____ _____ _____
Signature of Representative *Legal Relationship* *Date* *Signature of Witness*

Name: _____