AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/ ____/ _____

Date(s) of Service _____ Phone Number: _____

I hereby authorize: _____ (PHYSICIAN/HOSPITAL)

_____ (ADDRESS)

_____

_____ (TELEPHONE/FAX)

to release my health information to: Dr. Joyce Tatelman
2204 Grant Road, Suite 104
Mountain View, CA 94040
Phone 650 528-5110
Fax 650 528-5115

for the purpose of continuing care.

a. ____ I authorize the release of the following specific records _____
OR

b. ____ I authorize the release of my complete health records (including records relating to mental healthcare, communicable disease, HIV/AIDS and treatment of alcohol or drug abuse) **OR**

c. ____ I authorize the release of my complete health records with the exception of:

_____ Mental health records
_____ Communicable diseases (including HIV)
_____ Alcohol/drug abuse treatment
_____ Other (please specify) _____

EXPIRATION: This authorization shall become effective immediately and shall remain in effect for one year from the date signed unless a different date is specified here: _____

I may revoke this authorization at any time. My revocation must be in writing and be signed by me or on my behalf.

SIGNATURE: _____ DATE: _____
(PATIENT/LEGAL REPRESENTATIVE)