wellnessarchitecture
DESIGNING OPTIMAL HEALTH

Authorization for Use or Disclosure of Health Information

(This authorization for use or disclosure of my health information is required by state and federal law)

PATIENT'S NAME: ___________________________________DATE OF BIRTH:_______________

Daytime telephone: ________________________ Social Security Number: ______________________

I hereby authorize the party listed below to disclose and discuss my health information to ***Dr. Samia McCully, N.D.*** *in Menlo Park, California.*

Doctor/Family Member: ____

Clinic: ____

Address: ____

Phone/Fax: ____

Email Address: ____

Lab   Imaging reports   Immunizations   Other

Note that a specific authorization is required to release information regarding:

	Yes	**No**	**Initials**
HIV Information			________
Drug/Alcohol Information			________
Mental Health Information			________

Please mail/fax to:
Dr. Samia McCully
841 El Camino Real
Menlo Park, CA 94025
650-322-2161

Restrictions: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to the recipients outside the state of California.

This authorization shall be valid until ________. Please indicate a date after which no information can be released. If no date is given, authorization and my refusal will not affect my ability to obtain treatment. I may revoke this authorization at any time, in writing. The revocation must be signed by me or on my behalf and sent to the address above. The revocation is effective upon receipt but will have no impact on uses or the disclosures made while the authorization was valid.

I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION. Copy required? Yes No Copy received? Yes No

Patient Signature:____ Date:________________

Patient/Personal Representative Signature:____

Relationship to Patient:____