

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Note: Do Not Use This Form If Records To Be Released Relate To HIV Test Results.)

EXPLANATION: This Authorization is necessary for us to comply with state and federal laws pertaining to the use or disclosure of protected health information ("PHI") about the patient identified below. Please provide all requested information.

Name of Patient _____ Date of Birth _____

Other Names _____ M.R. or Account # _____

1. PERSONS AUTHORIZED TO DISCLOSE PHI. I authorize the following person(s) or class of persons to disclose the health information about patient as described in Section 2 below (State name of physician or specific identification of person or class of persons.):

2. DESCRIPTION OF INFORMATION. This Authorization permits the use and/or disclosure of the following information about a patient (Please initial.):

_____ (Initial) All my health information pertaining to any medical history, physical condition
And treatment received.
Except (optional): _____

3. AUTHORIZED USERS AND RECIPIENTS. I hereby authorize Terence A. Degan, M.D. and his staff, as necessary, to use the health information described in Section 2 above. Records may be sent to the following location:

Terence Degan, M.D.
1216 Suncast Lane, Suite 1
El Dorado Hills, CA 95762

4. I understand that I may be charged a reasonable fee for copying and sending my records.

Signature

Date