AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

I understand that my provider will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization.

I hereby authorize: To disclose to:

c/o agent Sharp Legal Imaging, Inc.
P.O. Box 549
Concord, CA 94522

records and information pertaining to:

Name of Member/Patient (List Other Names Used) | Medical Record Number | Date of Birth

Address | Telephone Number

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).

REVOCATION: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE: Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.S.F. part 2.

SPECIFY RECORDS: Check the box, initial and/or sign to specify which type of information is to be disclosed:

- ☐ MEDICAL INFORMATION
- ☐ PSYCHIATRIC INFORMATION
- ☐ DRUG/ALCOHOL INFORMATION
- ☐ RESULTS OF AN HIV TEST
- ☐ GENETIC RECORDS
- ☐ OTHER HEALTH INFORMATION

Specify the records to be disclosed:

The recipient may use the health information authorized on this form for the following purposes:

A copy of this authorization is as valid as the original.
Member/Patient has a right to a copy of this authorization.

Date | Signature | If Signed by Other than Member/Patient, Indicate Relationship