

Roger W. Washington, M.D.

**AUTHORIZATION FOR USE AND/ OR DISCLOSE
OF MEMBER/ PATIENT HEALTH INFORMATION**

I understand that Dr. Washington will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

I hereby authorize:

to disclose to:

Name of Disclosing Party: _____

Name of Recipient: ROGER W. WASHINGTON, M.D.

Address: _____

Address: 885 SCOTT BLVD., STE. 4
SANTA CLARA, CA 95050
(408) 246-9926 • (408) 246-7877

City: _____ State: _____ Zip: _____

City: _____ State: _____ Zip: _____

Telephone number: _____ Fax number: _____

Telephone number: _____ Fax number: _____

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).

REVOCAION: 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.

REDISCLASURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

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

- | | | |
|---|-----------------|-----------------|
| <input type="checkbox"/> MEDICAL INFORMATION | initial _____ | |
| <input type="checkbox"/> PSYCHIATRIC INFORMATION | signature _____ | date _____ |
| <input type="checkbox"/> DRUG/ ALCOHOL INFORMATION | signature _____ | date _____ |
| <input type="checkbox"/> RESULTS OF AN HIV TEST | signature _____ | date _____ |
| <input type="checkbox"/> GENETIC DISORDER | signature _____ | date _____ |
| <input type="checkbox"/> OTHER HEALTH INFORMATION | initial _____ | (specify below) |

Specify the records to be disclosed: _____

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

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 _____