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Authorization Form for Release of Confidential Health Information

(1) I hereby authorize Dr. _____ to disclose to Dr. _____ information from the health records of:

Patient Name: _____

Date of Birth: _____

Address: _____

(2) Information to be disclosed:

- | | |
|--|---|
| <input type="checkbox"/> Complete Health Record(s) | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> Progress Notes / Doctor's Notes | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Operative Notes | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Other (please specify) _____ |

(3) The above information for the following period of time shall be released:

From (date) _____ to (date) _____

(4) The purpose(s) of the authorization is (are) _____.

- I recognize that the information disclosed may contain drug/alcohol information that is protected by federal and state law.
- I recognized that the information disclosed may contain mental health information that is protected by federal and state law.
- I recognized that the information disclosed may contain information regarding HIV/AIDS information.

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refused to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will remain in effect until one year from the date of signature.

 Signature of Patient

 Date

If you are not the patient, please specify your relationship to the patient: _____