Gateway Medical Group of San Diego, Inc.

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize **GATEWAY MEDICAL GROUP of SAN DIEGO, Inc.** to use and disclose health information concerning:

Patient Name:______________________________________ **DOB:**______________________

Phone number:_________________________

Health information to be used or disclosed (please check all that apply):

- ❑ ALL RECORDS
- ❑ LABS
- ❑ X-RAY, CT SCAN
- ❑ Other/s:_________________________

For health services provided on (date) From:__________________ To:____________________

This health information may be disclosed to: (*Name and address of person to use or receive the health information*)

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The information may be used only for the following purposes:

___Continuing Medical Care ___Personal ___Legal __Insurance

___Other/s (please specify):___________________________________

This authorization is effective now and will remain in effect until (expiration date)**:**_____________ ***If no date indicated, authorization will expire one year from date of signature.**

I understand that I have the right to receive a copy of this authorization.

Signature:________________________________ **Date:**______________________________

Print Name: ______________________________ **Witness (Optional):**____________________

If not signed by the patient, please indicate relationship:________________________________

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