

Gateway Medical Group of San Diego, Inc

610 Euclid Avenue Suite 302 National City, CA 91950

Phone: (619) 527-7700 Fax: (619) 527-3226

752 Medical Center Court Suite 210 Chula Vista, CA 91911

Phone: (619) 656-0206 Fax: (619) 656-8936

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by 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 _____ 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:

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Phone: (619) 527-7700 Fax: (619) 527-3226

752 Medical Center Court Suite 210 Chula Vista, CA 91911
Phone: (619) 656-0206 Fax: (619) 656-8936

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: _____