Chabot Family Associates Inc.
PH: 510-582-6424 FAX : 510-582-6462
Email : CONTACT@KAREWELLMD.COM

Authorization for the Use or Disclosure of Health Information

1. I authorize _____ to disclose my health information to (name and address of recipient):

   _____

   _____

   _____

2. This authorization applies to [check one box]:

   ☐ Only the following records or type of information or specific dates of treatment:

   _____

   _____

   _____

   ☐ All health information pertaining to any medical history, mental or physical condition and treatment received. Includes information related to drug, alcohol and/or psychiatric conditions or conditions pertaining to sexually transmitted diseases, including AIDS. HIV test result information will NOT be released unless specifically requested (sign in box below if you wish to release this information).

   Exclusions: _____

   _____

   _____

Please release my HIV test results to the recipient listed in item #1.

Signed: _____

Dated: _____

3. The receiver may use the medical information that is being released for the following purposes (*if you do not want to explain the purpose, write "At the request of the individual*."):

   _____

   _____

   _____

4. This authorization expires: (date) _____

Please continue on reverse to complete the authorization.

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Your Rights

- I know that I may revoke this authorization to the extent that it has not already been relied upon. I may revoke this authorization by writing a statement that I withdraw my authorization for further release of the records.

- Any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules; however, California law prohibits the receiver from making further disclosure of my health information unless the receiver obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

- I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to assure treatment unless the sole purpose of the treatment/examination/evaluation is to provide information to a third party.

- I have a right to receive a copy of this authorization.

Signed: _____ Dated: _____

Print Name: _____

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

☐ parent or guardian of minor patient (to the extent minor could not have consented to the care)

☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased patient

☐ spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)