SAMUEL D. VAN KIRK, M.D. , FACOG 2139 AIRPARK DRIVE; REDDING, CA 96001
OBSTETRICS & GYNECOLOGY TEL: (530) 247-0270; FAX: (530) 247-0271

Authorization to Release Health Information (page 1 of 2)

Patient Name:_____ Date of Birth:_____

I voluntarily authorize and direct the health care provider named below to disclose my health information by means of mail, fax, or other electronic methods during the term of this Authorization to the recipient that I have identified below:

FROM: Name: _____

Address: _____

Telephone: _____ Fax: _____

TO: Name: _____

Address: _____

Telephone: _____ Fax: _____

PURPOSE: I understand that the specific purpose of this Authorization is:_____

_____

INFORMATION TO BE DISCLOSED: This authorization permits the above named health care provider to disclose:

□ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition, and any treatment received by me, including without limitation, x-rays; HIV/AIDS status; genetic testing; psychotherapy notes and other mental health information; drug, alcohol or other controlled substance information; billing information; correspondence and records from my other health care providers that the above-named health care provider may hold.

□ All of my health information described above except for the following:_____

_____

□ Only the following records or types of health information (Insert dates of treatment, types of treatment, or other designation): _____

_____

TERM: This Authorization will remain in effect for one (1) year from the date this authorization is signed.

REDISCLOSURE: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal or state law governing the use and disclosure of my health information.

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Authorization to Release Health Information (page 2 of 2)

REFUSAL TO SIGN/RIGHT TO REVOKE: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

REVOCATION: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before the provider received my written notice of revocation. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

QUESTIONS: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have the right to receive a copy of this authorization from my health care provider.

PHOTOCOPY: A photocopy, fax, or electronic copy of this authorization shall be considered as effective and as valid as the original.

Patient, Parent, or Guardian Signature: _____ Date: _____

Name (please print):_____

_____ (Initial) **I am aware that there will be a charge for this service as governed by the California Health and Safety Code #123110**