Authorization for the Release of Health Information

Information **FROM** Dr. Sato and Dr. Kimura's office **TO** another individual/facility

Patient name **Date of Birth**

Purpose of disclosing information

I hereby authorize the disclosure of my health information

From: **Naomi Sato, M.D., F.A.A.P. ● *PEDIATRICS* ● Robyn L. Kimura, M.D., F.A.A.P.**
900 Florin Road, Suite B ● Sacramento, California 95831 ● (916) 421-8245

To: ______________________________

Name of individual, facility, etc.

Address City State ZIP

( ) ( )

Phone Fax number

Type of health information to be released

This authorization is valid one year from the date of execution (unless otherwise indicated) and applies to the following information:

- ❑ All medical records pertaining to ______________________________
- ❑ All medical records from the following date(s)* ______________________________
- ❑ Other (specify) ______________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), behavioral and mental health services, and substance use. *I authorize the inclusion* of the following information:

- ❑ HIV/AIDS
- ❑ Behavioral or mental health services
- ❑ Sexually transmitted disease
- ❑ Substance use

Patient rights and restrictions on release of health information

Patient Rights

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment, payment or health plan enrollment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing signed by me or on my behalf, and delivered to this office. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have the right to receive a copy of this authorization. If initialed, I have requested and received a copy. Initials ________

California Restrictions

California law prohibits the recipient from making further disclosure of patient health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

Redisclosure

I understand that if the recipient of my information is not a healthcare provider, a health plan, or healthcare clearing house, or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such a recipient and my information may no longer be protected by state and federal laws.

PRINT NAME - Parent/Guardian (or patient if over 18 yrs) **Relationship to patient**

SIGNATURE- Parent/Guardian (or patient if over 18 yrs) **Date** **Daytime phone number**