## Authorization for the Release of Health Information Information FROM another individual/facility TO Dr. Sato and Dr. Kimura

| <u>I hereby authorize the disclosure of I</u>   | <u>my (or my child/ren's</u>     | <u>) health information</u>            |
|---|----------------------------------|--|
| From:   |                                  |  |
| Name of health professional, facility, etc.   |                                  |  |
| To: 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  |                                  |  |
| Patient name  | Date of Birth                    | Purpose of disclosing information      |
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| Type of health information to be relective This authorization is valid one year from the cand applies to the following information:  All medical records pertaining to  |                                  | herwise indicated)                     |
| $\square$ 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:  |                                  |  |
| Patient rights and restrictions on rele   | ease of health inform            | ation                                  |
| <ul> <li>Patient Rights</li> <li>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.</li> <li>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.</li> <li>I have the right to receive a copy of this authorization. If initialed, I have requested and received a copy. Initials</li> </ul> |                                  |  |
| California Restrictions California law prohibits the recipient from making fuobtains another authorization from you or unless the extend to recipients outside the state of California.   |                                  |  |
| <b>Redisclosure</b><br>I understand that if the recipient of my information i<br>house, or not an entity required to comply with fede<br>further disclosed by such a recipient and my informa   | ral or state health privacy regu | ulations, my health information may be |
| PRINT NAME - Parent/Guardian (or patient  | if over 18 yrs)                  | Relationship to patient                |
| SIGNATURE - Parent/Guardian (or patient i   | f over 18 yrs) Date              | Daytime phone number                   |