PEACHWOOD MEDICAL GROUP
AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide authorization.

Copies of the signed authorization will be considered as valid as the original

I hereby authorize _____
NAME OF DISCLOSING PARTY

_____
ADDRESS

_____
CITY STATE ZIP PHONE FAX

To disclose to **Amy Evans, MD / Dianne Hubbard, MD / Marty Martin, MD / Brad Sumrell, MD / Will van Beever, DO**
NAME OF RECEIVING PARTY

275 W Herndon Ave
ADDRESS

Clovis **CA** **93612** **(559) 324-6202** **(559) 324-6282**
CITY STATE ZIP PHONE FAX

Records and information pertaining to:

_____
NAME OF PATIENT (LIST OTHER NAMES USED) DATE OF BIRTH

_____
ADDRESS CITY STATE ZIP PHONE

DURATION: This authorization shall become effective immediately and shall remain in effect until_____ or for one year from the date of signature

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent the Requestor or others have acted in reliance upon the authorization

REDISCLOSURE: I understand that the requestor may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law

RECORDS: All medical information_____(initial). A separate authorization is required for HIV disclosure or psychotherapy notes.

Specify the records to be disclosed: _____

_____

The requester may use the health information authorized on this form for the following purposes only: _____

_____

I understand that I have the right to receive a copy of this authorization.

_____
Signature Patient/Legal Representative/Guardian Relationship to patient Date