LiveWell

MEDICAL CLINIC

343 El Camino Real, Suite 1, South San Francisco, CA 94080
P.650.873.3338 F.650.873.3308

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Patients Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Tel No.: _____ Mother's Name: _____ Mothers DOB: _____

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*I hereby authorize _____LiveWell Medical Clinic_____ to disclose information as specified below for the following purpose (s): _____

***Copies of records or medical information within the following dates:** _____to _____

☐ Both Hospital and Medical Office Records ☐ Medical Office Records ☐ Hospital Records
☐ X-Ray Films ☐ Laboratory Results ☐ Immunization Records ☐ Consultation Reports
☐ Records limited to a specific provider: _____ ☐ Other _____

NOTE: Hospital and Medical Office Records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.
The actual treatment records for mental health and/or alcohol/drug, and/or HIV antibody tests are specially protected and will not be disclosed unless you sign below:

Mental Health Records → Signature: _____
Alcohol/Drug Dependency treatment records → Signature: _____
HIV antibody test results → Signature: _____

☐ Check if the same as above (disclosure to patient)

The first 9 pages of medical records are provided free, as a courtesy to our patients. However, if the document requires 10 or more pages, a flat fee of $15 is required.

- **_____LiveWell Medical Clinic_____ (**Name of Hospital where baby was born or previous Clinic/Doctor) **may disclose this information to:**

Recipient Name: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Tel No.: _____ Fax No.: _____

Media Type: ☐ Electronic ☐ Paper **Delivery Preference:** ☐ Fax _____ ☐ Mail ☐ Pickup

DURATION: This authorization shall become effective immediately and shall remain in effect unless a different date is specified here _____ (date)

REVOCATION: This authorization is subject to written revocation by me at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon authorization.

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

A copy of this form can be given upon request.

*Date: _____ Signature: _____

If signed by other than the patient, Print Name/ (Relationship): _____ / (_____)