Balboa Nephrology Medical Group

9610 Granite Ridge Rd. Ste. B, San Diego, Ca 92123
Phone (858) 499-1900 FAX (858) 268-1911

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:
(print) _____ Date of Birth: _____

Physician: _____ Social Security or MRN # _____

I voluntarily request and authorize: **Balboa Nephrology Medical Group**
to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐
Other: _____

**Term:** This Authorization will remain in effect until revoked by the patient named above. Please see page two (2) for more information on revocation.

**Definition:** Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

PLEASE READ NOTICES AND CONDITIONS ON PAGE TWO (2) BEFORE SIGNING

Witnessed by
(print):_____Signature_____Date:_____

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

**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 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 receives my written notice of revocation.

**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 a 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.