Green Oaks Medical Center, PC
Christine Green, MD

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650-433-8925
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Authorization for Disclosure or to Obtain Health Information

1. Please check one of the following:
A.__ I hereby authorize the office of Dr. Green to **obtain** the following information from health records of:
B.__ I hereby authorize the office of Dr. Green to **disclose** the following information from health records of:

Patient Name:_____ Date of Birth:_____

2. This information will be disclosed or obtained from or to:
Name:_____Address:_____

Phone:_____ Fax:_____

For the purpose of:_____

Covering the Dates:_____ to _____

3. Information to be disclosed:
___Complete health record(s) ___discharge summary
___History & physical examination ___progress notes
___Consultation reports ___laboratory tests
___X-ray Reports ___photographs/videotapes/digital/other images
_other (please specify) _____

I understand that this will include information relating to (check if applicable):
___Acquired Immunodeficiency Syndrome (AIDS)
___Human Immunodeficiency Syndrome (HIV)
___behavioral health service/psychiatric care
___treatment for alcohol and/or drug abuse

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization.
Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

5. Green Oaks Medical Center, PC, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herein signed:

Patient/or Legal Representative_____ Date _____

Relationship to Patient_____ Date_____

Signature of Witness_____ Date _____