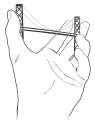

the hand center
OF SAN FRANCISCO

RECORDS RELEASE

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California Law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose any and all health information concerning:

_____

PATIENT NAME & ADDRESS

This health information may be disclosed to:

_____

NAME AND ADDRESS (OR FAX) OF PERSON DESIGNATED TO USE AND/OR RECEIVE THE HEALTH INFORMATION

The information maybe used only for the following purposes (if you do not want to explain the purpose, please write "At the request of the individual"):

_____

PLEASE SPECIFY ABOVE

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

EFFECT OF REFUSAL TO SIGN AUTHORIZATION

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form. This authorization is effective now and will remain in effect until _____

EXPIRATION EVENT OR DATE

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

_____

AUTHORIZED SIGNATURE | PRINTED NAME | DATE

If not signed by the patient, please indicate relationship below:

☐ Parent or Guardian of minor patient (to the extent minor could not have consented care)
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient

Kyle D. Bickel, M.D. Patrick O. Lang, M.D.

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