Palo Alto Medical Foundation
A Sutter Health Affiliate

ACTA MEDICAL SERVICES
795 EL CAMINO REAL
PALO ALTO, CA 94301
PH 650-853-2941 FAX 650-321-3548

MUST COMPLETE FORM IN ORDER TO AVOID ANY DELAYS PAMF # _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This authorization for use or disclosure of my health information is required by state and federal law.

* PATIENT'S NAME _____ DOB: _____
Last First MI

Daytime Telephone Number _____ Social Security No.: _____

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY HEALTH INFORMATION

PALO ALTO MEDICAL FOUNDATION
(NAME OF PERSON OR ORGANIZATION RELEASING INFORMATION)

795 EL CAMINO REAL
STREET ADDRESS

PALO ALTO, CA 94301
CITY STATE ZIP CODE

TO RELEASE MY HEALTH INFORMATION TO:

*
(NAME OF PERSON OR ORGANIZATION RECEIVING INFORMATION)

STREET ADDRESS

CITY STATE ZIP CODE

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:

☐ All records ☐ Lab ☐ Imaging Reports ☐ Immunizations

* ☒ Other **PAST ____ YEARS MEDICAL RECORDS**

THE RECIPIENT MAY USE MY HEALTH INFORMATION ONLY FOR THE FOLLOWING PURPOSE

*Important:
Please Check the
"YES" boxes, then
intial at the X's*

* (PLEASE SPECIFY) **INSURANCE / LEGAL**

A SPECIFIC AUTHORIZATION IS REQUIRED TO RELEASE INFORMATION REGARDING THE FOLLOWING:

* *** IMPORTANT:**
PLEASE CHECK THE "YES" OR "NO" BOXES THEN INITIAL AT THE X'S

	YES	NO	INITIALS
HIV Information	☐	☐	X _____
Drug/Alcohol Information	☐	☐	X _____
Mental Health Information	☐	☐	X _____

Restrictions: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

* This authorization shall be valid until X _____. Please indicate a date after which no information can be released. If no date is given, authorization is valid for 90 days only.

I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment.
I may revoke this authorization at any time, in writing. The revocation must be signed by me or on my behalf and sent to the address on the top of this form. The revocation is effective upon receipt but will have no impact on uses or disclosures made while the authorization was valid.

I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION. Copy Requested: ☐ Yes ☐ No Copy Received: ☐ Yes ☐ No

* Patient Signature X _____ Date X _____

Patient/Personal Representative Signature _____

Relationship to Patient _____

DISTRIBUTION: White - Record; Yellow - Copy

FORM 143444 (December 2003)