HT Family Physicians
77 W. March Ln., Suite A
Stockton, CA 95207
Phone: 209-477-5552
Fax: 209-477-5553

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize _____

_____

Name and address of entity to receive this information

to release certain protected health information (PHI) about me to **HT Family Physicians, Inc., 77 W. March Lane, Suite A, Stockton, CA 95207.**

Any and all individually identifiable health information may be released, including but not limited to *mental health records* protected by the Lanterman-Petris-Short Act, *drug and/or alcohol abuse records* and/or *HIV test results*, if any, except as specifically provided:_____

_____.

The information may be released for the purpose of medical treatment only. This authorization will expire one year from the date signed below.

The Practice will ___ will not _X_ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this release in order to receive treatment from HT Family Physicians, Inc. In fact, I have the right to refuse to sign this authorization. When my information is released pursuant to this authorization, it may be subject to redisclosure and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer of HT Family Physicians at 77 W. March Lane, Ste. A, Stockton, CA 95207.

Signed by: _____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____

Patient's Name | Patient's Date of Birth

_____ _____

Print Name of Patient or Legal Guardian | Date