HT Family Physicians, Inc.

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize **HT Family Physicians, Inc.** to release certain protected health information (PHI) about me to ___________
____.

Name and address of entity to receive this information

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 used or released only for the purpose of Medical Treatment.

This authorization will expire one year from the date signed below.

The Practice will ___ will not ____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 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