Associates in Family Medicine
M. Michelle Hamidi, MD
5222 Balboa Ave Suite #31
San Diego, CA 92117
Phone (858) 565-6394 Fax (858) 565-6471

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW

Patient Name:_____
Please Print Name

Patient's Date of Birth:_____

A. Person(s) or Organization(s) authorized to receive the information:
E.G., Spouse's Name and Phone Number, Family member's Name and Phone Number, Employer

B. Specific description of the information that may be used or disclosed (including dates):
E.G., Full Chart, Specific Date of Service

C. Specific description of how the information will be used:
E.G., Background check, School inquiries

D. I hereby authorize this practice to leave a detailed voicemail message regarding my healthcare issues or test results:
HOME _____ **CELL** _____ **and/or WORK** _____

1) **I understand that this authorization will expire one year from today's date.**
2) **I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Fairfax Family Practice Centers, PC in writing.**
3) **I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).**
4) **I may inspect or copy any information used or disclosed under this agreement.**
5) **I understand that, if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.**

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient