South Bay Sports & Preventive Medicine Associates, Inc.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Information and Accountability Act (HIPAA) and California law, your individually identifiable health information may not be used or disclosed except as provided incur Notice of Privacy Practices without your authorization. Your completion of this form grants permission for the use and disclosure of your health information as described below. Please review and complete this form carefully. It may not be valid if not fully completed.

Patient Information:

Name:_____ Date of Birth: _____

Address:_____

Phone Number:_____

Health information to be disclosed □ to □ from:

Medical Practice or Provider Name: _____

Address:_____

Phone: _____ Fax:_____

□ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Latermin-Peris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except specifically provided below.

_____

This information is to be disclosed □ to □ from:

South Bay Sports and Preventive Medicine Associates, Inc.

550 S. Winchester Blvd, Suite 100

San Jose, CA 95128

Phone: 408-293-7767 Fax: 408-300-9663

□ Anthony Saglimbeni, MD □ Chris Chung, MD □ Kenneth Akizuki, MD □ Amy Hockenbrock, MD

□ Teresa Mueting, FNP □ Robert Nashime, MD

This information may be used for the following purposes (if you do not wish to explain the purpose, you may write "at the request of the individual"): _____

_____

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 1 year from the date of signature.

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

Signed: _____ Date: _____

Print Name:_____ If not signed by patient indicate relationship: _____