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: ________________________________

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:

West Coast Sports Institute

900 Lafayette St, Suite 105
Santa Clara, CA 95050
P: 408-293-7767
F: 408-300-9663

280 Jackson St
San Jose, CA 95112
P: 408-293-5864
F: 408-300-9663

2250 Hayes St, Suite 208
San Francisco, CA 94117
P: 415-259-4101
F: 408-300-9663

□ Anthony Saglimbeni, MD □ Chris Chung, MD □ Amy Hockenbrock, MD □ Robert Nishime, MD

□ Kenneth Akizuki, MD □ Sara Edwards, MD □ John Kao, MD □ Caroline Bittner, PA-C □ Nicola Juri, PA-C

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”): ____

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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.

Print Name: _______________________________ Sign: __________________________________

Date:__________________ If not signed by patient indicate relationship: ___________________________