

TRANSFER RECORDS FROM AIMMG TO OTHERS

**AUTHORIZATION FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Patient's Name: _____ Date of Birth: _____

I hereby authorize Associated Internal Medicine Medical Group, Inc. (AIMMG) to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from AIMMG, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from AIMMG. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. An authorization is not required for AIMMG to use PHI for treatment, payment, or business operations.

This authorization covers the following PHI:

Category of PHI

All health information pertaining to any medical history, mental or physical condition and treatment received. Includes information related to drug, alcohol and/or psychiatric conditions or conditions pertaining to sexually transmitted diseases, including AIDS. HIV test result information will NOT be released unless specifically requested. (sign below if you wish to release HIV test results)

HIV test results to the recipient listed below.

Signature _____ Date _____

Amount of PHI

Entire PHI in the chosen category [Example – All "HIV Test Results"]

Please limit use and disclosure of my PHI to:

The recipient(s) of my PHI is (are):

I authorize my PHI to be used and disclosed:

At my request

For

[SPECIFY PURPOSE]

Patient's Name _____

For CLINICAL TRIAL: I understand that AIMMG may refuse provision of research-related treatment unless I sign an authorization for use and disclosure of my PHI for the research. I understand that I will not have access to my PHI while the clinical study is open, but will be provided access when the study is closed.

For MARKETING: I understand that AIMMG may receive monetary compensation from the party receiving my PHI or that party's affiliates.

This authorization will expire: _____
[SPECIFY DATE OR EVENT]

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying AIMMG in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by AIMMG in reliance on this authorization before AIMMG receives my request for revocation or modification. I must sign my written request and send it to:

Associated Internal Medicine Medical Group, Inc., 350 30th Street, Suite 320,
Oakland CA 94609

Signed: _____ Dated: _____

If not signed by the patient, please indicate relationship:

Parent, guardian or caregiver of a minor patient. Guardian or conservator of an incompetent patient.

Beneficiary or personal representative of a deceased patient.

Other _____
[SPECIFY RELATIONSHIP]

**There is a chart copy fee. The copy service will bill you.
If you have any questions, please contact the office at 510-465-6700**