

TRANSFER RECORDS FROM OTHERS TO AIMMG

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

Patient's Name: _____ Date of Birth: _____

Hereby authorize-

Address:

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 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. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

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 of my PHI is Dr . _____

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

Patient's Name _____

I authorize my PHI to be used and disclosed:

At my request

For _____

[SPECIFY PURPOSE]

For CLINICAL TRIAL: I understand that _____ 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 _____ 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 _____ in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by _____ in reliance on this authorization before _____ receives my request for revocation or modification. I must sign my written request and send it to:

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]