

**AUTHORIZATION FOR RELEASE OF  
PROTECTED HEALTH INFORMATION FROM  
EAST BAY FAMILY PRACTICE MEDICAL GROUP, INC.**

**Patient's Name:** \_\_\_\_\_

**Patient's Date Of Birth:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

I hereby authorize East Bay Family Practice Medical Group, Inc. (EBFP) 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 EBFP, 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 EBFP. 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**

- |   |   |
|---|---|
| <input type="checkbox"/> Medical Records  | <input type="checkbox"/> Claims/Billing Information |
| <input type="checkbox"/> HIV Test Results | <input type="checkbox"/> Other _____                |

**Amount of PHI**

- Entire PHI in the chosen category [Example – All "HIV Test Results"]
- Please limit use and disclosure of my PHI to: \_\_\_\_\_
- [Examples – "Laboratory results from July 1998"; "Medical records from January 2001 to present"]

**Please mail/FAX this Protected Health Information (PHI) to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

FAX: \_\_\_\_\_

I authorize my PHI to be used and disclosed:

- At my request
- For \_\_\_\_\_ [SPECIFY PURPOSE]

This authorization will expire: \_\_\_\_\_ [SPECIFY DATE OR 1 YEAR]

East Bay Family Practice Medical Group, Inc contracts with DataLink Inc. to process medical records. Upon receiving this signed authorization to release records and a \$15 copy fee (please make check payable to DataLink), your chart will promptly be copied and mailed to the recipient listed above. Your records will be sent on a CD-ROM, or if you would prefer a paper copy please contact DataLink after your records have been copied, (888) 997-7299.

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

East Bay Family Practice Medical Group, Inc.  
3100 Telegraph Ave. Suite 2109  
Oakland, CA 94609-3210  
Attn: Medical Records Department

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

Print Name: \_\_\_\_\_ SS# : \_\_\_\_\_

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 ]