

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information, about you.

Patient's Name: _____

Date of Birth: _____

Phone # _____

Social Security: _____

I request and authorize _____

(address,ph,fax) _____

To Release healthcare information of the patient named above to:

Name: _____ or
Address: _____

Michael K. Lloyd, M.D. Inc.
460 Greenfield Ave. Ste.#3
Hanford, CA 93230
Ph: 559-584-5770
Fax: 888-774-0477

This request & authorization applies to:

- a. All health information pertaining to my medical history, mental or physical condition – OR
- Only the following records or types of health information. Include date(s) of treatment:

b. I specifically authorize release of the following information (check as appropriate):

Mental health treatment HIV test results Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

Purpose of requested use or disclosure: Patient request (); OR () other:

Expiration date: _____ (This authorization will expire in 6 months unless otherwise indicated).

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:
Michael K. Lloyd, M.D., 460 Greenfield Ave. Ste #3, Hanford, CA 93230
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to and will receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by Federal confidentiality law (HIPAA).

Signature: _____ Print: _____ Date: _____
(Patient/representative/spouse/financially responsible party)

(If signed by someone other than the patient, state your legal relationship to the patient)