Authorization to Disclose Personal Health Information

In an effort to protect your privacy, please fill out the following items if you authorized Calderon Medical Group (CMG) to disclose information about your health to the individuals listed below.

Patients Name: _____ Date of Birth:_____

CMG will only disclose the personal health information you want disclosed.

1. Please check only one box below to inform CMG what the specific health information you want disclosed:

- o Limited information (go to question 2b)
- o Any information (go to question 3)

2b. Complete this section only if you selected "limited information". Check all that apply:

- o Information about your medication changes refills
- o Information about your current condition and diagnosis
- o Information about your Specialist/other services referred to
- o Information about your discussion of your latest office visit
- o Information about your current plan of management
- o Information about your insurance, account balance, payments
- o Other specific information:_____

3. Check only one box below indicating how long CMG can use this authorization to disclose your personal health information (subject to applicable law):

- o Disclose my personal health information indefinitely
- o Disclose my personal health information for a specified time period only
  Starting date (mm/dd/yy)_____
  Ending date (mm/dd/yy)_____

4. Fill in the name and address of the person(s) or organization(s) to whom you authorize CMG to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:

(a)Name_____

Address, city, state_____

Phone Number_____

(b)Name_____

Address, city, state_____

Phone Number_____

(c)Name_____

Address, city, state_____

Phone Number_____

(d)Name_____

Address, city, state_____

Phone Number_____

I authorize CMG to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law. I further understand that the persons listed above will still need to know my date of birth and other information for security reasons when asked by the staff of CMG. Without the knowledge of this information, no personal health information will be discussed.

Print Patient Name:_____ Todays Date_____

Patient Signature:_____ Telephone Number_____