AUTHORIZATION FOR USING AND DISCLOSING HEALTH INFORMATION

Adult Med House-Call Physicians

Phone: 925 324-8227 E-mail: DrLaurie@LD-MD.com Web: LD-MD.com

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information no longer be protected by federal privacy regulations.

Patient Name: ________________________________

ID Number or date of birth__________________

Physician/ Hospital Providing the Information: ______________________________

Persons/Organizations Receiving the Information: ***Laurie F. Draughon, M.D., 231 Market Place, Suite 115, San Ramon, CA 94583***____________________________

Specific Description of Information (Including Dates); _________________________

____

I understand that this authorization will not expire. Initials: ____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Initials: _____

You have the right to revoke this authorization at any time, provided you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By (patient): ____________________________________ *Date:* _____________

Or By: ____ *Date:* ______________

(Patient's Representative)

Description of Representative's Authority: _________________________________

____