AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

GINA TOBALINA, M.D., INC.

As required by the Health Information Portability Act of 1996 (HIPAA) and California Law, this practice may not use or disclose your individually identifiable health information, except as provided in our Notice of Privacy Practices, without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully, as it may be invalid if not thoroughly completed accurately. Before signing this disclosure, you may ask the person and/or entity that you want to receive your information to complete the sections detailing the information to be release and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning:

____ ____________________

PATIENT NAME **DATE OF BIRTH**

Provider/Entity information:

______________________________________ ______________________________________

DOCTOR/FACILITY **ADDRESS**

______________________________________ ______________________________________

TELEPHONE **FAX**

Health Information to be used or disclosed (*check only one box*):

[ ] Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/ or alcohol abuse records; and/ or HIV test results, if any except, as specifically provided below: ______________________________

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[ ] All psychotherapy notes may be release, except as specifically provided below: ______________

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The requested health information is to be released/ disclosed to:

Gina Tobalina, M.D.

1615 Creekside Drive, Suite 101 T (916) 817-4132

Folsom, CA 95630 F (916) 817-4148

- I understand I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to this receipt.
- I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan, or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it, except as specifically required or permitted by law.

This authorization is effective now and will remain in effect until __________________(expiration date)

- I understand I have the right to receive a copy of this authorization.

____ ____________________

SIGNATURE **DATE**

If not signed by patient, please indicate relationship: ______________________________

Office Use Only:

Faxed: ________

Initials: ________