

Danielle Acton, M.D., FAAFP
Sumana Reddy, M.D. FAAFP
Rafael Siqueiros, M.D.
Margaret Simon, M.D.



8036 San Miguel Canyon Rd.
Prunedale, CA 93907
(831) 663-0123

400 E. Romie Lane
Prunedale, CA 93907
(831) 770-0123
Fax: (831) 753-9717

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

**REQUEST FOR RELEASE OF
MEDICAL RECORDS FROM:**

TO:

Name of Individual or Organization

Address

City, State, Zip

Name of Individual or Organization

Address

City, State, Zip

This _____ authorization

The information will be used or disclosed for the following purpose:

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on: Clinical Care
Expiration Date or Defined Event

The Practice will _____ will not _____ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Acacia Family Medical Group**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: **400 E. Romie Lane
Salinas, CA 93901**

Signed by: _____
Signature of Patient or Legal Guardian

Relationship to Patient

Print: _____
Print Name of Patient/Legal Guardian

Print Name of Patient/Legal Guardian

Other Names Used by Patient

Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION