



AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. Copies of the signed authorization will be considered as valid as the original.

I hereby authorize **NIKKI BANH, MD/ NAZZI MOJIBI, MD/ MARY GONZALEZ-HOWARD MD**

To disclose to

NAME OF PARTY

ADDRESS

CITY

STATE

ZIP

PHONE

FAX

Records and information pertaining to:

NAME OF PATIENT

DATE OF BIRTH

ADDRESS

CITY

STATE

ZIP

PHONE

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the Requester or others have acted in reliance upon the Authorization.

REDISCLASURE: I understand that the requester may not lawfully further use or disclose the health information unless another Authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

RECORDS: All medical information [REDACTED] (INITIAL) A separate authorization is required for HIV disclosure or psychotherapy notes.

Records to be disclosed: All vaccine records, last well visit report, last sick visit report, growth charts, diagnostic tests, labs, and medication list.

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

PATIENT/LEGAL REPRESENTATIVE/GUARDIAN

RELATIONSHIP TO PATIENT

DATE