

John Gambin, M.D. Kurt Osborn, M.D. Thomas Krenek, M.D. Donald Iverson, M.D. Melissa McKenzie, D.O.

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: _____ Patient's D.O.B.: _____

Previous Name(s): _____

PROVIDER: **Humboldt Neurological Medical Group, Inc.**
(Who is releasing the **2828 O'Neil Lane, Eureka, CA 95503**
information sent)

INFORMATION:

- Complete Records
- Health care information relating to the following treatment/condition/dates:

- Other (please specify): _____

PURPOSE:

- Transferring Medical Care
- Moving
- Other (please specify) _____

INFORMATION SENT TO: Name: _____ Fax: (_____) _____
Address: _____

Specific Authorization for Release of Information Protected by State or Federal Law:

I specifically authorize the release of data, results, and information relating to:

- SUBSTANCE ABUSE (alcohol and/or drug)
- SEXUALLY TRANSMITTED DISEASES (Including, but not limited to HIV and/or AIDS)
- MENTAL HEALTH (Includes Psychological Testing)

The authorization is **effective for one year** from the date on which it was signed. I understand that I may **revoke** this authorization at any time, except to the extent that action has been already taken in reliance upon it, by giving written notice to Humboldt Neurological Medical Group, Inc. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by Humboldt Neurological Medical Group, Inc. The statements made are binding, controlling, and I understand that they take precedence over statements made in the HNMG Notice of Privacy Practices.

Signature of Patient or
Legal Representative: _____ Date: _____
Relationship to Patient,
If not signed by Patient: _____ Witness: _____

This authorization to release health information is voluntary. Treatment may not be conditioned based on this Authorization, except for the following circumstances (1) to obtain information in connection with eligibility or enrollment in a health plan, (2) to determine an entity's obligation to pay a claim, or (3) to create health information to provide to a third party. HNMG is required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. You are entitled to receive a copy of this authorization.