RELEASE AUTHORIZATION FORM

Davis Shields, M.D
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To: David Shields, MD ☐ From: David Shields, MD ☐

Authorization For Use or Disclosure Of Health Information

This authorization for use or disclosure of my health information is required by state and federal law.

Patient Name:____
Last First Date of Birth

Daytime Phone:_________________________ Social Security #_____________________

I Hereby Authorize The Use Of Disclosure Of My Health Information By:

Name of Person or Organization Releasing Information:_______________________________
Street Address:____
City:_____________________________State:_____________Zip Code:____________

To Release My Health Information To:

Name of Person or Organization Receiving Information:_______________________________
Street Address:____
City:_____________________________State:_____________Zip Code:____________

This Authorization Applies To The Following Information:

☐ All Records ☐ Lab and Imaging Records ☐ Immunization
☐ Other:____

Specific Authorization Is Required For The Following Information

HIV Information	Yes	☐	No	☐	Initials _________
Drug/Alcohol Information	Yes	☐	No	☐	Initials _________
Mental Health Information	Yes	☐	No	☐	Initials _________

AUTHORIZED USE OF RELEASED INFORMATION HEALTH CARE

Restriction: California Law Prohibits The Recipient From Making Further Disclosures Of Your Health Information Unless The Recipient Obtains Another Authorization. From You Or Unless The Disclosure Is Required Or Permitted By Law. This Protection Does Not Extend To Recipients Outside of California. This Authorization Shall Be Valid Until____________________, After Which No Information Can Be Released. If No Date Is Given Authorization Is Valid for 90 Days.

I May Refuse To Sign This Authorization And My Refusal Will Not Affect My Ability To Receive Treatment. I May Revoke This Authorization At Any Time, In Writing, Signed By Me Or On My Behalf And Sent To The Address At The Top Of The Form. The Revocation Is Effective Upon Receipt, But Will Have No Impact On Uses Or Disclosures Made While The Authorization Was Valid.

I Have A Right To A Copy Of This Form: Requested: Yes____ No____

Patient Signature:_____________________________________Date:____________________

OR

Patient/Personal Representative Signature:____
Relationship To Patient:_________________________________ Date:____________________