Authorization for use/disclosure of Patient Health Information

I hereby authorize:

Castro Valley Pediatrics
22290 Foothill Blvd., Ste. 1
Hayward, CA 94541
510-581-1446
FAX 510-581-1805

□ Dr. Donald Selcer □ Dr. Mika Hiramatsu
□ Dr. Willie Ross □ Dr. Caren Vance
□ Dr. Jerrilyn Johnson □ Dr. Yasmin Carim

To disclose to :

Physician's Name (please print)
Address:_____

City:_____State:_____Zip Code_____

Records and information pertaining to:

Name of patient_____

Date of Birth:_____
(mm/dd/yyyy)

Patient/Parent signature_____

Duration: This authorization shall become immediately effective and shall remain in effect for one year from the date of signature unless a different date is specified here:_____

Revocation: This authorization is also subject to written revocation, and will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

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