RECHARGE MEDICAL

recharge.clinic

San Francisco • Walnut Creek
phone: 415-409-3456 • fax: 415-500-2417

Permission to disclose

By default your health information is protected, which means that a physician or staffmember of Recharge Medical is not permitted to share your information with other unauthorized parties. In some cases, it is desirable or necessary to share your health information, such as when doing so intends to improve your health. To do so legally and ethically, we need your explicit permission. Carefully consider the information our physician or staffmember has provided you about the need to share your information, and if you agree, complete this form.

If possible, use Adobe Acrobat or Adobe Reader to complete this on a computer before printing or emailing. (Other applications might seem to work but are not compatible. Use only either of these.)

My name is:
Other names I have used are:
My birthdate is:
My telephone number is:

I authorize:

Name:
Address:
Phone number:
Fax number:

To disclose to:

Name:
Address:
Phone number:
Fax number:

The following records:

☐ All medical records excluding psychotherapy notes

☐ Medical records:

from (mm/yy):	to (mm/yy):

☐ Medical records related to:

☐ Just medical billing and payment records (this includes codes for diagnosis and procedures)

☐ Testing records, i.e., x-rays, labs (excluding HIV-related testing)

☐ A summary or explanation of the indicated records in place of the actual records

And these special records:

My signed initials _____ confirm that for the following records requiring special request I also authorize disclosure about my treatments for:

	yes	no
1. mental health	☐	☐
2. developmental disability	☐	☐
3. HIV/AIDS	☐	☐
4. substance abuse	☐	☐

By this method:

Choose one:

PDF on disc	☐
paper	☐
HIPAA e-transfer	☐

Because:

(optional)

And this permission expires:

If no date is given, then this permission expires one year from the date signed.

Agreement

I confirm that this form has been fully completed.

I understand that:

1. I'm not required to grant this permission.
2. Refusing to grant permission will not affect my ability to obtain treatment or payment or eligibility for benefits.
3. I may revoke this authorization at any time by submitting a written request to Recharge Medical, 1456 California Street, San Francisco, CA 94109. This revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this permission.
4. I may receive a copy of this document upon request.
5. There might be administrative fees associated with this agreement not to exceed

   for which I am solely responsible.
6. Information legally disclosed by Recharge Medical could be disclosed to others by the receiving party. If this happens, in some cases your health information *is not* protected by law. However, if the permission granted is for the disclosure of substance abuse information, the receiving party might be prohibited from disclosing the information. For more information about this, ask your Recharge Medical physician or staffmember.

Printed name of patient	Printed name of guardian	Signature of patient or guardian	Date and time