THE
Mills-Peninsula
MEDICAL GROUP
A PROFESSIONAL CORPORATION

STANDARD RELEASE AND AUTHORIZATION FORM

Federal law requires Mills Peninsula Medical Group to protect the privacy of the information that identifies you and relates to your past, present, and future physical and mental health and conditions ("protected health information").

Completion of this form authorizes the use/disclosure of protected health information, as set forth below, consistent with California and federal law concerning the privacy of such information. Please provide all information requested to ensure your authorization is valid.

RESTRICTIONS:
California law prohibits the recipients from making further disclosure 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 the state of California.

MY RIGHTS:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits.

- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address:
  Attn: Privacy Officer
  Mills - Peninsula Medical Group
  P.O. Box 4348
  Burlingame, Ca. 94011-4348

- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.

- I have a right to receive a copy of this upon written request

- I may inspect and obtain a copy of the health information that I am authoring for use or disclosure upon written request to Mills Peninsula Medical Group.

- If this box [ ] is checked, Mills Peninsula Medical Group will receive compensation for the use or disclosure of my health information.

AFTER SIGNING, PLEASE MAKE A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS AND THEN MAIL OR FAX BACK TO:
Member Services
Mills Peninsula Medical Group
P.O. Box 4348
Burlingame, Ca. 94011-4348
Fax# 650-240-0973

Use and disclosure of protected health information

I hereby authorize the use/disclosure of my protected health information as follows:

Member Demographics:

*Name: _____ *Birth Date: _____
*Address:
*City, State, Zip: _____ *Phone#: _____
*Health Plan: _____ *ID#: _____

Persons/Organizations authorized to disclose the protected health information:

Mills – Peninsula Medical Group

*Person/Organizations authorized to receive the protected health information:

_____

*Purpose of requested use/disclosure:

_____

*This authorization applies to the following protected health information (select only one of the following):

☐ All protected health information pertaining to any medical history, mental or physical condition and treatment received.

☐ All protected health information pertaining to any medical history, mental or physical condition and treatment received, except: _____

_____

☐ Only the following records or types of protected health information (including any dates):

_____

EFFECTIVE DATE AND EXPIRATION

*This authorization becomes effective on _____ and will expire on _____

SIGNATURE OF MEMBER/PERSONAL REPRESENTATIVE

*Date: _____ *Time: _____ AM/PM

*Signature: _____
(Member/personal representative)
*Witness: _____

*If signed by someone other that the member, print your name below and your legal relationship to the member:

_____

**All fields marked with an asterisk must be completed for this document to take effect.*