*Amethyst Medical Group - Winni Loesch, MD, FAAFP*
*123 Margaret Lane, Ste C2, Grass Valley, CA 95945*
*Telephone (530)798-5003 Fax (530)271-2338 www.amethystmed.com*
*"It's not just about how sick you are…It's about how well you can be!"*

## Authorization for use or Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, Amethyst Medical Group may not use or disclose your individual identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed.

Patient Name _____ Date of Birth _____

Patient Address _____

Patient Phone _____

I authorize the following person (s) to receive my Protected Health Information (PHI)

| Name | Relationship | Phone | Information used for following purpose |
|---|---|---|---|
| _____ | _____ | _____ | ( )At the request of the individual<br>( )To provide information to family & friends<br>( )Other_____ |
| _____ | _____ | _____ | ( )At the request of the individual<br>( )To provide information to family & friends<br>( )Other_____ |
| _____ | _____ | _____ | ( )At the request of the individual<br>( )To provide information to family & friends<br>( )Other_____ |
| _____ | _____ | _____ | ( )At the request of the individual<br>( )To provide information to family & friends<br>( )Other_____ |

This authorization shall be in force and in effect from the date of signature for 1 year.

I understand that I have the right to revoke this authorization, in writing, at anytime.

By signing this consent form, I give permission to the person(s) listed above to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPPA compliant authorization.

_____ _____

Patient Signature Date