



STANDARD RELEASE AND AUTHORIZATION FORM

Brown & Toland Physicians ("Brown & Toland") is committed to protecting the privacy of 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 your protected health information, as set forth below, consistent with applicable California and federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this authorization.**

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this authorization.
 - I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:
 - ATTN: Privacy Officer
 - Brown & Toland Physicians
 - P.O. Box 640469
 - San Francisco, CA 94164-0469
 - My revocation will be effective upon receipt by Brown & Toland. However, the revocation will not be effective to the extent that Brown & Toland or others have acted in reliance upon this authorization after the effective date of the authorization and prior to the date of revocation.
 - I have a right to receive a copy of this authorization upon written request.
 - Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
 - Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality laws. However, California law prohibits the person receiving my protected health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
 - I may inspect or obtain a copy of the protected health information that will be used or disclosed under this authorization, upon written request to Brown & Toland.
 - I understand that multiple health plans offer Brown & Toland as an option to their enrollees. I also understand and agree that this authorization will continue to be valid as long as I am enrolled with Brown and Toland, regardless of the health plan to which I belong, subject to all other parameters defined in this authorization, including expiration date and my right to revoke this authorization at any time.
- If this box is checked, Brown & Toland will receive compensation for the use or disclosure of my information.

After signing, please make a copy of this authorization for your records and then mail or fax back to:

Brown & Toland Physicians
P.O. Box 640469
San Francisco, CA 94164-0469
Fax: _____

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:

Brown & Toland Physicians

Persons/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)

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