

**Jane R. Reldan, M.D., Inc.**  
7946 Ivanhoe Ave., Ste 312 • La Jolla, CA 92037  
858.459.6600 • FAX 858.459.6605  
jreldan@san.rr.com

**AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION**

**Patient Information**

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

**Authorization for Use/Disclosure of Information:** I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Name of Provider: \_\_\_\_\_  
Address of Provider: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

**Recipient and Address for Delivery of Records:**

Jane R. Reldan, M.D., Inc.  
7946 Ivanhoe Ave, Ste 312  
La Jolla, CA 92037  
858-459-6600  
858-459-6605 FAX

**Purpose:** I understand that the specific purpose of this Authorization is:

\_\_\_\_\_

**Information to be disclosed:** This authorization permits the above named health care provider to disclose the following medical records:

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes, and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.
- All of my health information described above except for the following:  
\_\_\_\_\_
- Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)  
\_\_\_\_\_

**Jane R. Reldan, M.D., Inc.**  
7946 Ivanhoe Ave., Ste 312 • La Jolla, CA 92037  
858.459.6600 • FAX 858.459.6605  
jreldan@san.rr.com

---

**Term:** This Authorization will remain in effect for one (1) year from the date this authorization is signed.

**Redisclosure:** I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

**Refusal to sign/right to revoke:** I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation

**Revocation:** I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

**Questions:** I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have the right to

**Photocopy:** A photocopy, fax, or electronic copy of this authorization shall be considered as effective and as valid as the original.

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Name (Please Print)*

\_\_\_\_\_  
*Witness Signature*

If Individual is unable to sign this Authorization, please complete the information below.

\_\_\_\_\_  
*Signature of Legal Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Legal Relationship*

\_\_\_\_\_  
*Witness Signature*

\_\_\_\_\_  
*Name (Please Print)*