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**Jose Calderon-Abbo, MD, LLC**

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**AUTHORIZATION for USE or DISCLOSURE of PROTECTED HEALTH INFORMATION**

I authorize my clinician and/or administrative staff to disclose general medical information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of this clinic.

**NAME and RELATIONSHIP of person(s) you wish to allow access – for example; your spouse, child, sibling, neighbor, caretaker, clergy, or close friend:**

**NAME OF PERSON or ENTITY**

**RELATIONSHIP**

_____	_____
_____	_____
_____	_____
_____	_____

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me, or, if the purpose of the disclosure is related to research, at the end of the research study.

I understand that the information used or disclosed pursuant to this authorization may be disclosed by my clinician and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to my clinician. I understand that a revocation is not effective to the extent that my clinician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Regardless of whether you provide us with this authorization, services and billing/payment operations will be conducted. However, if your treatment is for any of the following purposes, we have the right not to provide you with medical services:

- 1) If your treatment is related to research
- 2) If health care services are provided to you solely for the purpose of creating protected health information for disclosure to a third party

**CLIENT STATEMENT:** I have read and fully understand and agree with the above policy and conditions.

\_\_\_\_\_  
**PATIENT SIGNATURE or PERSONAL REPRESENTATIVE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**Print name of Patient or Personal Representative**

\_\_\_\_\_  
**Description of Personal Representative's Authority**