William H. Gentry, MD, FACS

430 Rio Street * Red Bluff, CA 96080
Phone: 530-528-0801 * Fax: 530-528-2608

Authorization for Request, Use, or Disclosure of Protected Health Information

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. Copies of this signed authorization will be considered as valid as the original and available to patient upon request.

I hereby authorize: _____
Name of Disclosing Party
_____
Address
_____
City, State, ZIP
_____
Phone/Fax

To disclose to: William H Gentry, MD FACS
Name of Receiving Party
430 Rio St
Address
Red Bluff, CA 96080
City, State, ZIP
530 528-0801/ 530 528-2608
Phone/Fax

Records pertaining to: _____
Name of Patient Date of Birth
_____
Address Phone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for a period of 1 year from date of signature or until_____.
Date

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLOSURE: **I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.**

SPECIFY RECORDS: Check the box and initial to specify which type of information is to be disclosed

- ❑ Medical Information _____ Initial
- ❑ Psychiatric Information _____ Signature date
- ❑ Drug/Alcohol Information _____ Signature date
- ❑ Results of an HIV blood test _____ Signature date
- ❑ Other Health Information as specified below:

_____
_____
_____
_____

USE: The requester may use the health information authorized on this form for these purposes:

- ❑ Evaluation and/or Treatment.
- ❑ Other:_____
_____

Signature: _____ Date: _____