



John W. Alchemy, M.D., A Medical Corporation
2360 Mendocino Ave., Suite A-2 325, Santa Rosa, CA 95403
Phone (707) 304-7579 | Fax (206) 338-3005
Email: Info@JohnAlchemyMD.com

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
(A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.)**

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, consistent with California and Federal law. Failure to provide all requested information may invalidate this authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION:

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: _____
Patient Date of Birth: _____ SSN: _____
Persons/Organizations authorized to use or disclose the information: _____

Persons/Organizations authorized to receive the information: All providers and/or medical consultants; medical institutions; medical practices Dr. Alchemy deems necessary to conduct and manage my medical care.

Purpose of requested use or disclosure: To conduct and manage my medical care.

This Authorization applies to the following information (select one):

☒ All health information pertaining to any medical history, mental or physical condition and treatment received.

☐ [Optional] Except: _____

☐ Only the following records or types of health information (including dates): _____

EXPIRATION:

This authorization expires (insert date or event): Ten (10) years from date of signing, unless otherwise noted.

If no date is indicated, the authorization will expire 12 months after the date of signing.

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 appropriate address.

My revocation will be effective upon receipt but will not apply to actions already taken based on this authorization.

I have the right to receive a copy of this authorization.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by HIPAA. However, California law limits redisclosure without authorization except as permitted by law.

I may inspect or obtain a copy of the health information that I am being asked to disclose.

If this box ☐ is checked, the Requestor will receive compensation for use or disclosure of my information.

Signature Section:

Date: _____ Time: _____

Signature (patient/representative/spouse/financially responsible party): _____

If signed by someone other than the patient, state relationship: _____

Witness: _____

If this box is checked: ☐ I have been offered and decline a copy of this document but may request one at any time.