MEDICAL RECORDS AUTHORIZATION
OF PROTECTED HEALTH INFORMATION

Patient's Name: ______________________________ Date of Birth: ____________________

I hereby authorize (place medical records are wanted from) __________________________________
____
to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

This authorization covers the following PHI:

Category of PHI

□ Medical Records □ Claims/Billing Information □ Mental Health Records
□ Drug/Alcohol Abuse □ HIV Test Results □ MRI and X-ray Records

Amount of PHI

□ Entire PHI in the chosen category (*Example*—All "HIV test Results")
□ Please limit use and disclosure of my PHI to:

____
(*Examples*—"Laboratory results from July 1998"; "Mental health records from January 2001 to present")

The recipient of my PHI:
□ Ravi Panjabi, M.D. □ Riddhi Patel, PA-C
□ Navin Mallavaram, M.D. □ JoAnn Dumas, F.N.P.

□ 19850 Lake Chabot Rd, Castro Valley, CA 94546 (P) 510-582-8555 (Fax) 510-581-8686
□ 1081 Market Place, # 100, San Ramon, CA 94583 (P) 925-242-0810 (Fax) 510-581-8686
□ 2324 Santa Rita Rd, #9, Pleasanton, CA 94566 (P) 925-846-1701 (Fax) 510-581-8686

Signed: ____________________________________ Dated: ______________________

If not signed by the patient, please indicate relationship:
□ Parent, guardian or caregiver of minor patient
□ Guardian or conservator of an incompetent patient
□ Beneficiary or personal representative of a deceased patient
□ (Spouse, etc.) ____ (SPECIFY RELATIONSHIP)