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Authorization for Disclosure or Release of Health Information

As required by the Health information Portability and Accountability Act of 1996 (HIPAA) and California law, our office may not use or disclose your personal health information except as provided in our Notice of Privacy Practice without your authorization. Your completion of this form means you are giving permission for release described below. Please review and complete this form carefully. It may be invalid if not completed.

I hereby authorize this medical practice to use or disclose health information concerning

_____ (patient name)

Person(s) authorized to receive my medical information:

1. my insurance company
2. primary care physician and other treating physicians
3. spouse
4. parent(s)
5. family members, please indicated names _____
6. others, please indicate _____

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

This AUTHORIZATION is effective now and will remain in effect until further notice.

I understand that I have a right to receive a copy of this authorization.

Signed: _____ Date: _____

Print Name: _____

Signature of Personal Representative (if applicable) _____