AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ , hereby authorize _____
(Name of Patient, DOB) (Name of person or facility which has information)

to release the following health information: ALL MEDICAL RECORDS

except as noted:

To:

KELLY A. SHARRAR, M.D. (FAMILY PHYSICIAN)
(Name and title or facility name to receive health information)

4981 INDIAN PEAK, MARIPOSA, CA 95338 (209) 682-5228 (209) 682-5227
(Street address, city, state, ZIP code) (Telephone number) (Fax number)

For the following purposes: CONTINUING MEDICAL CARE

This authorization is in effect until _____ (date or event), when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Patient:	Date
Or Signed by Personal Representative: _____ On Behalf of _____ Name of Patient	Date