AUTHORIZATION TO USE and/ or DISCLOSE MEDICAL INFORMATION

I hereby authorize:

_____
NAME OF DISCLOSING PARTY (prior medical provider)

_____
OLD DOCTORS ADDRESS

_____
CITY STATE ZIP

_____ _____
DOCTOR'S PHONE DOCTOR'S FAX

To disclose and release all medical records to:

Dr. Kathryn Amacher, DO
269 Sage Sparrow Circle
Vacaville, CA 95687
Phone: 707-451-4111
Fax: 707-451-9803

RECORDS AND INFORMATION PERTAINING TO:

_____ _____
PATIENT NAME (Please Print) **DATE OF BIRTH**

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of this signature.
REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt by Dr. Kathryn Amacher, DO, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.
REDISCLOSURE: I understand that once the medical provider discloses my health information to the recipient, Dr. Kathryn Amacher DO cannot guarantee that they will not disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable law governing the use and disclose my health information. I understand that the medical provider may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

DATE OF AUTHORIZATION: _____

PATIENT SIGNATURE IN FULL: _____

POWER OF ATTORNEY SIGNATURE: _____