

I understand that this information may not be further disclosed unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Patient or legally authorized individual signature Date/time

Printed name if signed on behalf of patient Relationship to patient