GROVE INTERNAL MEDICINE, INC.

8283 GROVE AVE. STE. 201
RANCHO CUCAMONGA CA 91730
(909) 981-6644 fax (909) 981-5048

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I HEREBY AUTHORIZE TO DISCLOSE MY PROTECTED HEALTH INFORMATION IN THE MANNER DISCRIBED BELOW. I UNDERSTAND THAT THE RECIPIENT OF MY PHI MAY NOT FURTHER DISCLOSE THE INFORMATION UNLESS THE RECIPIENT OBTAINS ANOTHER AUTHORIZATION FROM ME OR UNLESS THE DISCLOSURE IS SPECIFICALLY REQUIRED OR PERMITTED BY LAW. I FURTHER UNDERSTAND THAT THE HEALTH CARE PROVIDER WILL NOT CONDITION THE PROVISION OF CARE OR THE RECEIPT OF BENEFITS ON THE SIGNING OF THIS AUTHORIZATION.

PATIENT INFORMATION

NAME: DOB: PHONE #:

STREET ADDRESS: CITY:

STATE: ZIP CODE:

CATEGORY OF PHI:

☐ MEDICAL RECORD

☐ CLAIMS/BILLING INFORMATION

☐ DRUG/ALCOHOL ABUSE INITIAL

☐ MISC INFORMATION SPECIFY BELOW:

AMOUNT OF PHI:

☐ LAST 2 YEARS OF PHI IN THE CHOSEN CATEGORY

☐ LIMIT USE/DISCLOSURE OF MY PHI

TO:

RECIPIENT:

GROVE INTERNAL MEDICINE, INC.
8283 GROVE AVE. STE. 201
RANCHO CUCAMONGA CA 91730

REASON FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION:

THIS AUTHORIZATION WILL EXPIRE SIX MONTHS FROM THE DATE SIGNED, UNLESS SPECIFIED: I UNDERSTAND THAT I WILL BE PROVIDED WITH A COPY OF THIS AUTHORIZATION AND THAT I MAY REVOKE OR MODIFY THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE HEALTH CARE PROVIDER IN WRITING. 1 MUST SIGN MY WRITTEN REQUEST AND SEND IT TO:

SIGNED: DATED: WITNESSED:

IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE RELATIONSHIP:

☐ PARENT OR GUARDIAN/CAREGIVER OF A MINOR CHILD

☐ GUARDIAN OR CONSERVATOR OF AN INCOMPETENT PATIENT

☐ BENEFICARY OR PERSONAL REPRESENTATIVE OF DECEASED PATIENT