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Disclosure of Health Information Authorization

I. I hereby authorize Dr. Yoko Kay Tanaka the use or disclosure of my protected health information as described below and understand and acknowledge the following:

1. I am not required to sign this authorization and may in fact refuse to sign this authorization.
2. Dr. Yoko Kay Tanaka will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law.
3. If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
4. I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.
5. I have the right to revoke this authorization at any time.
6. My revocation must be in writing and submitted to Dr. Yoko Kay Tanaka. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.
7. If I have any questions about this authorization, I may contact Dr. Yoko Kay Tanaka, who will provide me
8. with more information about this authorization, or about her privacy practices.
9. If this authorization is for psychotherapy notes, it may not authorize the use or disclosure of any other type of protected health information.

II. Patient Name: _____ Soc. Sec# _____

Address: _____ City, State, Zip: _____

III. This authorization applies to the specific information set forth below:

IV. The following persons or organizations are authorized to receive my protected health information identified above:

Name: _____ Voice Phone: _____

Address: _____ Fax Number: _____

City, State, Zip: _____

V. This authorized use or disclosure is for the following specific purpose(s):

VI. This authorization will expire on ___/___/___ (dd/mm/yr); or upon the following event:

I certify that I have read, signed and know that I have a right to receive a copy of this authorization.

Signature of Patient (or personal representative): _____ Date: _____

Personal Representative's Name:

Relationship of Patient Representative to Patient: _____