Jeffrey M. Davidson, M.D.

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AUTHORIZATION TO USE AND/OR DISCLOSE PRIVATE HEALTH INFORMATION

I hereby authorize:

Jeffrey M Davidson, MD
Name of Disclosing Party

180 Montgomery St, Ste 2370
Address

San Francisco, CA 94104
City State ZIP

415.433.6673 415.433.6063
Phone Fax

To disclose to:

Name of Recipient

Address

City State ZIP

Phone Fax

Records and information pertaining to

Name of Patient (Specify Previous Names Used) | Social Security Number | Date of Birth

Address | Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here_____(Date).

REVOCATION: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization

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REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such uses or disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box and initial to specify which type of information is to be disclosed.

- ❑ **ALL RECORDS** _____ Initial
- ❑ **LAB RESULTS** _____ Initial
- ❑ **SKIN TESTS** _____ Initial
- ❑ **IMMUNOTHERAPY EXTRACT CONTENTS** _____ Initial
- ❑ **IMMUNOTHERAPY RECORDS** _____ Initial

Specify other records to be disclosed:_____
The recipient may use the health information authorized on this form for the following purposes:

A copy of this authorization is as valid as the original.
Patient has the right to copy this authorization.

SIGNATURE:

Date | Signature | If Signed by Other than Patient, Indicate Relationship