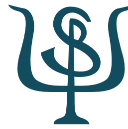
Svetlana Bonner, MD



550 Hamilton Ave #229
Palo Alto, CA 94301

650.323.1851 phone
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# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ______________________ , hereby authorize ______________________
*(Name of Patient)* *(Name of person or facility which has information)*

to release the following health information:

______________________

To: ______________________
*(Name and title or facility name to receive health information)*

______________________
*(Street Address, city, state, ZIP code)*

______________________ ______________________
*(Telephone Number)* *(Fax Number)*

For the following purposes:

______________________

This authorization is in effect until ______________________ , when it expires.
*(Date or Event)*

**I understand that by signing this authorization:**

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtain

| *Signed by Patient:* | *Date* |
|---|---|
| *Or Signed by Personal Representative:*<br>______________________<br>*On Behalf of (print name of patient)*<br>______________________ | *Date* |