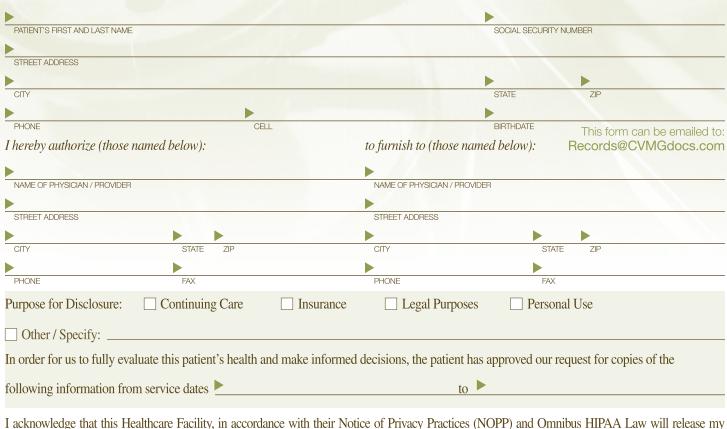


This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Privacy Act:



I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. Unless otherwise revoked, this authorization will expire one year from the date of signature. I understand that signing this form is voluntary, and that I may revoke this authorization at any time in writing, which must be mailed to 16465 Sierra Lakes Parkway, Suite 300, Fontana, CA 92336. I understand that I have the right to inspect and/or obtain a copy of the material to be disclosed. Cucamonga Valley Medical Group will not re-disclose this information, except with a written authorization or as specifically required or permitted by law. Cucamonga Valley Medical Group will not condition the provision of care or the receipt of benefits on signing this authorization. A copy of this authorization shall be as effective as the original and I have the right to receive a copy of this authorization. I release, hold harmless and agree to indemnify this Healthcare Facility, it's employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

I specifically authorize this Healthcare Facility to use and disclose verbally, by mail, fax, encrypted or unencrypted email, the following types of super-confidential information as stated in the NOPP. *Initial where appropriate:* 

Alcohol and substance abuse diagnosis and treatment records	INITIALS	HIV records (including HIV test results) and sexually transmissible diseases	INITIALS	Mental Health Records
•			•	
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN			DATE	
•			•	
SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE (IF APPLICABLE)			DATE	
•			•	
PRINT NAME OF PATIENT'S LEGAL REPRESENTATIVE (IF APPLICABLE)			RELAT	TONSHIP TO PATIENT