

**Authorization to Disclose Protected Health Information**

I hereby authorize *Flory Isabel Aguilar, M.D.* to disclose to the below named Facility / Physician.

OR

I hereby authorize the below named Facility/Physician to disclose to *Flory Isabel Aguilar, M.D.*

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

The following protected health information:

Entire File  
Laboratory Results  
Imaging Results (x-rays, CT scan, MRI, etc.)  
HIV results  
Progress Notes  
Medications  
Other: \_\_\_\_\_

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless *Flory Isabel Aguilar, M.D.* has taken action in reliance upon it. I also understand that such revocation must be in writing and received by *Flory Isabel Aguilar, M.D.* to be effective.

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by the Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Representative if patient is a minor: \_\_\_\_\_