

GROVE INTERNAL MEDICINE, INC.  
8283 GROVE AVE. STE. 201  
RANCHO CUCAMONGA CA 91730

(909) 981-6644  
fax (909) 981-5048

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I HEREBY AUTHORIZE \_\_\_\_\_ TO DISCLOSE MY PROTECTED HEALTH INFORMATION IN THE MANNER DESCRIBED BELOW. I UNDERSTAND THAT THE RECIPIENT OF MY PHI MAY NOT FURTHER DISCLOSE THE INFORMATION UNLESS THE RECIPIENT OBTAINS ANOTHER AUTHORIZATION FROM ME OR UNLESS THE DISCLOSURE IS SPECIFICALLY REQUIRED OR PERMITTED BY LAW. I FURTHER UNDERSTAND THAT THE HEALTH CARE PROVIDER WILL NOT CONDITION THE PROVISION OF CARE OR THE RECEIPT OF BENEFITS ON THE SIGNING OF THIS AUTHORIZATION.

**PATIENT INFORMATION**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

<b>CATEGORY OF PHI:</b>	<b>AMOUNT OF PHI:</b>
<input type="checkbox"/> MEDICAL RECORD	<input type="checkbox"/> LAST 2 YEARS OF PHI IN THE CHOSEN
<input type="checkbox"/> CLAIMS/BILLING INFORMATION	CATEGORY
<input type="checkbox"/> DRUG/ALCOHOL ABUSE INITIAL _____	<input type="checkbox"/> LIMIT USE/DISCLOSURE OF MY PHI
<input type="checkbox"/> MISC INFORMATION SPECIFY BELOW: _____	TO: _____

RECIPIENT: \_\_\_\_\_

Grove Internal Medicine, Inc.  
8283 Grove Avenue, Suite 201  
Rancho Cucamonga, CA 91730

REASON FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION: \_\_\_\_\_

THIS AUTHORIZATION WILL EXPIRE SIX MONTHS FROM THE DATE SIGNED, UNLESS SPECIFIED: \_\_\_\_\_  
I UNDERSTAND THAT I WILL BE PROVIDED WITH A COPY OF THIS AUTHORIZATION AND THAT I MAY REVOKE OR MODIFY THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE HEALTH CARE PROVIDER IN WRITING. I MUST SIGN MY WRITTEN REQUEST AND SEND IT TO:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNED: \_\_\_\_\_ DATED: \_\_\_\_\_ WITNESSED: \_\_\_\_\_

IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE RELATIONSHIP:  
 PARENT OR GUARDIAN/CAREGIVER OF A MINOR CHILD  
 GUARDIAN OR CONSERVATOR OF AN INCOMPETENT PATIENT  
 BENEFICIARY OR PERSONAL REPRESENTATIVE OF DECEASED PATIENT