Yaron Friedman MD, Inc.
Gynecology & Obstetrics

(925) 301 9875
Walnut Creek • Brentwood

Authorization for use and/or disclosure of patient information:

I herby authorize: Yaron Friedman MD Inc.

To release to and/or request from:

_____

_____

_____

Requesting records pertaining to:

_____
Name

_____
Date of Birth

Information to be disclosed (check all that apply)

- ❑ All Medical Records
- ❑ Mammogram Reports
- ❑ Pathology Reports
- ❑ Surgery Reports
- ❑ Laboratory Results
- ❑ Other_____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature.

REVOCATION: This authorization is subject to written revocation by the Undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective up receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.

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

_____ _____
Patient Signature **Date**

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