

# ALPINE ORTHOPAEDIC MEDICAL GROUP, INC.

PETER B. SALAMON, M.D.  
EDWARD L. CAHILL, M.D.  
VINCENT C. LEUNG, M.D.  
GEORGE W. WESTIN, JR., M.D.  
GARY T. MURATA, M.D.  
STEVEN E. EAGER, M.D.  
ROLAND H. WINTER, M.D.  
ANH X. LE, M.D.  
ALAN T. KAWAGUCHI, M.D.  
GARY M. ALEGRE, M.D.  
VANESSA BEEMAN, PA-C

JAMES V. ROCHE, M.D.  
1924-2001  
EMERITUS  
ROBERT M. HERMANN, M.D.  
W. PAUL MOUCHON, M.D.

ANNE McCUNE, MS, HSA  
ADMINISTRATOR

## Authorization for Alpine Orthopaedic Medical Group, Inc. to Release Copies of Medical Records (Protected Health Information)

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. We will evaluate your request and will either grant it or explain the reason why the request will not be granted.

I hereby authorize Alpine Orthopaedic Medical Group, Inc., 2488 N. California Street, Stockton, CA 95204 - (209) 948-3333 to disclose health information concerning:

(Patient name & address):

Tiffany Kay Anderson

Date of Birth: 8-22-1970 This authorization is effective now & will remain effective until 10-10-2010

### Health information to be used or disclosed (check box):

- Any and all health information may be released, including, but not limited to, medical health records protected by the Lanterman-Petris-Short Act\*, drug and alcohol abuse records\*, and HIV test results\*, if any, except as specifically described below

all records in chart

This health information may be disclosed to:

Tiffany Kay Anderson  
(Name & address of person to use or receive the health information)

pt to pick up

The information may be used only for the following purposes:

to keep for personal use

I understand that I may revoke this authorization at any time notifying this medical practice in writing. I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. I understand that I have the right to receive a copy of this authorization.

Signed: SAA Print Name: Tiffany Kay Anderson

Date: 10-6-2007

\*Signed by Treating Physician: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient (to the extent minor could not have consented to the care)  
 guardian or conservator of an incompetent patient  
 beneficiary or personal representative of deceased patient  
 spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

\*For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released. Under HIPAA, an authorization for release of psychotherapy notes may not be combined with an authorization involving any other type of health information (except other psychotherapy notes).  
Revised: 8/1/08

Team Physicians for the University of the Pacific Tigers  
and the Stockton Ports

2488 North California Street • STOCKTON, CA 95204-5508 • TELEPHONE: (209) 948-3333

