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**AUTHORIZATION TO USE AND/OR DISCLOSE PRIVATE HEALTH INFORMATION**

**I hereby authorize:**

\_\_\_\_\_  
Name of Disclosing Party

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State ZIP

\_\_\_\_\_  
Phone Fax

**To disclose to:**

\_\_\_\_\_  
JEFFREY M. DAVIDSON, M.D.  
Name of Recipient

\_\_\_\_\_  
180 MONTGOMERY ST., SUITE 2370  
Address

\_\_\_\_\_  
SAN FRANCISCO CA 94104  
City State ZIP

\_\_\_\_\_  
(415) 433-6673 (415) 433-6063  
Phone Fax

**Records and information pertaining to**

\_\_\_\_\_  
Name of Patient (Specify Previous Names Used) Social Security Number Date of Birth

\_\_\_\_\_  
Address Telephone Number

**DURATION:** This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here \_\_\_\_\_ (Date).

**REVOCACTION:** This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization

**REDISCLASURE:** I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such uses or disclosure is specifically required or permitted by law.

**SPECIFY RECORDS:** Check the box and initial to specify which type of information is to be disclosed.

- |   |         |  |         |
|---|---------|--|---------|
| <input type="checkbox"/> <b>ALL RECORDS</b> | _____   | <input type="checkbox"/> <b>IMMUNOTHERAPY EXTRACT CONTENTS</b> | _____   |
|   | Initial |  | Initial |
| <input type="checkbox"/> <b>LAB RESULTS</b> | _____   | <input type="checkbox"/> <b>IMMUNOTHERAPY RECORDS</b>          | _____   |
|   | Initial |  | Initial |
| <input type="checkbox"/> <b>SKIN TESTS</b>  | _____   |  |         |
|   | Initial |  |         |

Specify other records to be disclosed: \_\_\_\_\_

The recipient may use the health information authorized on this form for the following purposes:

\_\_\_\_\_  
A copy of this authorization is as valid as the original.  
Patient has the right to copy this authorization.

**SIGNATURE:**

\_\_\_\_\_  
Date Signature If Signed by Other than Patient, Indicate Relationship

Jeffrey Davidson, M.D.