

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NOTE: Fees may apply to certain requests

Patient Name: _____
Date of Birth: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Phone #: _____

I hereby authorize the following:

Name: _____
Address: _____
City, State: _____
Zip Code: _____
Phone #: _____
Fax#: _____

To disclose/release my protected health information as described below:

Recipient Name: _____
Address: _____
City, State: _____
Zip Code: _____
Phone#: _____ Fax#: _____

The following information:

- a. *All health information* pertaining to my medical history, or physical condition and the treatment received (this **does not** include any mental health, alcohol or substance abuse, or HIV information that is subject to special confidentiality protections)
- b. *Only the following* records of health information (include approximate or exact service dates if known): _____

The purpose for the release: Patient Request Other (state reason) _____

MY RIGHTS

- I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- Upon my request, I may receive a copy of this Authorization upon completion.
- I may revoke this Authorization at any time, but I must do so in writing and submit it to the address listed above. My revocation of a prior Authorization will take effect upon receipt, except to the extent that others have acted in reliance upon that Authorization.
- Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure might not be protected by California law or federal HIPAA law, depending on the circumstances. California law prohibits such re-disclosure without a new written authorization except as specifically permitted or required by law.
- This authorization shall remain in effect for one year from the date of the signature unless another date is specified here _____

Signature: _____ **Printed Name:** _____
Relationship to Patient: _____ **Date:** _____