AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

EXPLANATION: This Authorization is necessary to comply with state and federal laws pertaining to the use or disclosure of protected health information ("PHI") about the patient identified below. Please provide all requested information. Failure to provide all requested information may prevent us from acting on this Authorization.

Name of Patient: _____ Date of Birth: _____

Other Names: _____ Account #: _____

1. **PERSONS AUTHORIZED TO DISCLOSE PHI.** I authorize the following person(s) or class of persons to disclose the health information about patient as described in Section 2 below:

_____
Name of Physician or Medical Group

_____
Address

_____ _____
Phone Fax

2. **DESCRIPTION OF INFORMATION.** This Authorization permits the use and/or disclosure of the following information about patient: (Check all applicable boxes and initial section as required)

☐ _____ (initial) All my health information pertaining to any medical history, physical condition and treatment received. Except (optional): _____

OR

☐ _____ (initial) Only the following records or types of health information and/or only on the specified date(s):
Date(s) of Treatment: _____ Type of Treatment: _____

3. **AUTHORIZED USERS AND RECIPIENTS**. I hereby authorize the following person or class of persons to receive and/or use the health information described in Section 2 above:

_____
Name of Physician or Medical Group

_____
Address

_____ _____
Phone Fax

4. **PURPOSE.** I hereby authorize the information checked in Section 2 above to be used and/or disclosed for the purpose of medical treatment, payment, and benefits.

5. **RIGHT OF REVOCATION.** I understand that I have the right to revoke this authorization at any time, providing that my revocation is in writing and conforms to requirements described in the Notice of Privacy Practices.

6. **LIMITS TO REVOCATION.** I understand that my revocation will be effective upon its receipt by the person(s) I authorized in Section 1 but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the person(s) I authorized to receive and use health information described in Section 3, if patient (or personal representative) requested the Authorization, any revocation will be effective only when I communicate my revocation directly to them.

7. **REDISCLOSURE.** I understand that if the recipient of my information in Section 2 above is not a healthcare provider, a health plan or a health care clearing house or not any entity required to comply with federal or state health privacy regulations, my heath information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws. If this Authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the substance abuse information under federal substance abuse confidentiality requirements.

8. **CALIFORNIA RESTRICTIONS.** I understand that a recipient of medical information in California may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or benefits.

9. **RIGHT TO REFUSE TO SIGN.** I understand that do have the right to sign this authorization and that my failure to sign this authorization will not affect my ability to obtain treatment, payment, or benefits.

10. **DURATION.** This authorization will remain valid for the duration of time the patient named above is under the care of the Authorized physician, unless a different end date is specified. Date: _____

11. **COPY RECEIVED.** I acknowledge a receipt of a signed copy of this authorization _____ (Initials)

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Print Name of Patient or Personal Representative	Relationship of Personal Rep. to Patient
_____	_____
Address	Phone Number
_____	_____
Type of Patient/Representative ID presented	Signature of Employee who verified ID

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE