Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

_____ ___

Patient Name: _____ MRN: _____
Date of Birth: _____
Address: _____
Telephone#: Home: _____ Mobile: _____

Persons/Organizations authorized to use or disclose the information: [1]

_____

Persons/Organizations authorized to receive the information (must include name, address, phone number, fax number): _____

_____

This Authorization applies to the following information (select only one of the following): [2]

A. ❒ All dictation and test results
❒ All health information pertaining to any medical history, mental or physical condition and treatment received. [Optional] Except: _____
❒ Only the following records or types of health information (including any dates):
_____

B. I specifically authorize release of the following information (check as appropriate): [2,3]
❒ Mental Health treatment information
❒ HIV test results
❒ Alcohol / Drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure: [4] ❒ Patient request; ***OR*** ❒ Other:

_____

EXPIRATION

This Authorization expires (not to exceed 6 months): [5] _____
(Insert Date or Event)

NOTICE OF RIGHTS AND OTHER INFORMATION

• I may refuse to sign this Authorization.

• I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:

_____

• My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

• I have a right to receive a copy of this authorization. [6]

• Neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. [7]

• Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

• I may inspect or obtain a copy of the health information that I am being asked to use or disclose. If this box ❒ is checked, the Requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Date: _____Time: _____a.m./p.m.

Signature:

_____

(Patient / Representative / Spouse / Financially Responsible Party)

If signed by someone other than the patient, state your legal relationship to the patient: [8]

Witness: _____

Hospital Representative Processing Request: _____Date: _____

(Signature)

1. If the Authorization is being requested by the entity holding the information, this entity is the Requestor.
2. This form may **not** be used to release both psychotherapy notes and other types of health information (see 45 CFR“164.508 (b)(3)(ii). If this form is being used to authorize the release of psychiatric health information, a separate form must be used to authorize release of any other health information. An authorization for use or disclosure of HIV test results must **specifically** state that it authorizes the use or disclosure of HIV test results and must be signed by a witness.

3. If mental health information covered by Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party.
4. The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
5. If authorization is for the use or disclosure of protected health information for research, including the creation and maintenance of a research database or repository, the statement "end of research study", "None", or similar language is sufficient.
6. Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR"164.508 (d)(1), (e) (2)).
7. If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.
8. The requestor is to complete this section of the form.
9. Your signature below indicates you have received a copy of this authorization.

_____	_____	_____
(Patient Signature)	(Date)	(Witness)

Reference: Welfare and Institutions Code Section 5328.7

To be Completed by HIM Staff only

Copy of Record: ❒Picked up by _____ ❒Mailed to _____
❒Other _____

Date: _____ Time: _____ HIM Employee Signature: _____