State of California

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

All sections must be completed for the authorization to be valid.

Use "N/A" if not applicable Form: Page 1 of 2

Part 1 - Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Medical Reference Nº: _____ Date of Birth: _____

Address: _____ City/State/ZIP: _____

Part II - Individual/Organization Authorized to Release PHI

Name: _____

Address: _____ City/State/ZIP: _____

Part III - Individual/Organization Authorized by Signatory to Receive PHI

Name: _____

Relationship to Patient: _____ Phone: _____

Address: _____ City/State/ZIP: _____

Part IV - Authorization Expiration Event or Date

Unless otherwise revoked by the patient, this authorization for the release of PHI to the above-named individual/organization will expire on the event or date specified below, or 12 months from the date in Part IX.

Expiration Event: _____ Expiration Date: _____

Part V - Health Records to be Released - General

I authorized the following records to be released:

❑ Medical Records ❑ Dental Records ❑ Other

If Other, please specify: _____

Part VI - Health Records to be Released - Specific

❑ Communicable Diseases	Signature:_____	Date: _____
❑ Genetic Testing	Signature:_____	Date: _____
❑ HIV Test Results	Signature:_____	Date: _____
❑ Medication Treatment	Signature:_____	Date: _____
❑ Mental Health	Signature:_____	Date: _____
❑ Substance Use Disorder	Signature:_____	Date: _____

Requests for psychotherapy notes require a separate authorization and may not be combined with any other request for health records.

❑ Psychotherapy Notes Signature:_____ Date: _____

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Part VII - Purpose for the Release or Use of the Information

❑ Health Care ❑ Personal ❑ Legal

❑ Other (please specify): _____

Part VIII - Authorization Information

I understand the following:

1. I authorize the use or disclosure of the health information as described above for the purpose listed. I understand this authorization is voluntary.

2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party entered in Part II. The revocation will prevent further release of my health information from the date of receipt.

3. I am signing this authorization voluntarily and understand my health care treatment will not be affected if I do not sign this authorization.

4. The party entered in Part III is prohibited from re-disclosing the health information except with a written authorization or as specifically permitted by Cal. Code §56.10 or required by law (applies within California only).

5. If the party entered in Part III is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the released health information may no longer be protected by federal and state privacy regulations.

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

7. Fees may be charged to cover the cost of releasing the health information.

8. I understand that my substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization.

Part IX - Signature by or on Behalf of Patient

Name of Patient (Print): _____

Signature: _____ Date: _____

Name of person signing form if not patient: _____

Authority to sign on behalf of patient: _____

Name of translator (if applicable): _____

Signature of translator (if applicable): _____