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 #:_____

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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) _____

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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:_____