AUTHORIZATION FOR RELEASE OF INFORMATION

YOUR INFORMATION			
Last Name:	First Name:	Middle Name:	Date of Birth:
Address:	City/State/Zip:	CDC/YA Number:	

Person/Organization Providing the Information	Person/Organization to Receive the Information
Name: _____ Address: _____ City/State/Zip: _____ Phone #: (_____)_____ Fax Number: (_____) _____	Name: _____ Address: _____ City/State/Zip: _____ Phone #: (_____)_____ Fax Number: (_____) _____
[45 C.F.R. § 164.508(c)(1) (iii) & Civ. Code § 56.11(e), (f)]	

Description of the Information to be Released
(Provide a detailed description of the specific information to be released)
[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code §§ 56.11(d) & (g)]

☐ Medical	☐ Mental Health	☐ Genetic Testing
☐ Dental	☐ Substance Abuse/Alcohol	☐ Communicable Disease
☐ HIV	☐ Psychotherapy Notes	☐ Other (Please Specify)

_____.

For the following period of time: From _____ (date) to _____ (date)

Description of Each Purpose for the Use or Release of the Information
(Indicate how the information will be used)
[45 C.F.R. § 164.508(c)(1)(iv)]

☐ Health Care	☐ Personal Use	☐ Legal

☐ Other (please specify) _____

Will the health care provider receive money for the release of this information?
[45 C.F.R. § 164.524 (c) (4) (i), (ii)]

Reasonable fees may be charged to cover the cost of copying and postage.

This authorization for release of the above information to the above-named persons/organizations will expire on: _____ (date). [45 C.F.R. § 164.508(c)(1)(v) & Civ. Code § 56.11(h)]

I understand:

- **I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. [45 C.F.R. § 164.508(c)(2)(i)]**
- **I have the right to revoke this authorization by sending a signed notice stopping this authorization to the health Records department at my current institution. The authorization will stop further release of my health information on the date my valid revocation request is received in the Health Records department. [45 C.F.R. § 164.508(c)(2)(i) & Civ. Code § 56.11(h)]**
- **I am signing this authorization voluntarily and that my treatment will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii)]**
- **Under California law, the recipient of the protected health information under the authorization is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. [45 C.F.R. 164.508(c)(2)(ii)]**
- **I understand I have the right to receive a copy of this authorization. [Civ. Code § 164.508 (c)(4) and Civ. Code § 56.11(i)]**

Signature:	**CDC/YA Number:**	**Date:**

[45 C.F.R. § 164.508(c)(1)(vi) & Civ. Code § 56.11(c)(1)]

Representative:	**Relationship:**	**Date:**

[45 C.F.R. § 164.508(g)(1) & Civ. Code § 56.11(c)(2)]