AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning:

Name :	Date of Birth:
Social Security #	Address:

Received From: (name or person sending health information)	Disclosed To: (name and person receiving health information)

Health information to be used or disclosed (check *only one box*): *

Name of Patient:_____

□ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:
Records to be released are for 2 years unless otherwise specified: _____

□ Complete Records	□History & Physical	□Progress Notes
□ Care Plan	□Lap Reports	□Radiology Reports
□Pathology Reports	□Treatment Record	□Operative Reports
□Hospital Reports	□Medication Record	□ Immunizations only
□Colonoscopy (last on record)	□Other (please specify):	

□ All psychotherapy notes may be released, except as specifically provided below:

_____

_____

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual):

_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing.

My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

I understand that if I do not sign this form:

A health plan may not enroll me or make me eligible for benefits.

My physician will not perform the expert, employment, life insurance or other physical or medical evaluation which would otherwise be performed solely for the purpose of disclosure to a third party.

This authorization is effective now and will remain in effect until _____ (*Expiration event or date*).

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

□parent or guardian of minor patient(to the extent minor could not have consented to the care	□guardian or conservator of an incompetent patient
□beneficiary or personal representative of deceased patient **	□spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

Name of patient: _____

*****Signed: _____ Dated: _____
Treating Physician

***** *For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released. Under HIPAA, an authorization for release of psychotherapy notes may not be combined with an authorization involving any other type of health information (except other psychotherapy notes).*

****** *It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain records containing HIV test results.*