**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

**Medical Record Number:**

**Patient Name:**

**A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.**

**Date of Birth:**

I authorize _____ to release health information to:

_____

Name of person or facility to receive health information.

_____

Specify name/title of person to receive health information, if known.

_____

Street Address, City, State, Zip Code

_____

Phone Number

Purpose of requested use or disclosure:_____

_____

***INFORMATION TO BE RELEASED***

- ☐ Discharge Summary
- ☐ Billing Statements
- ☐ Pathology Reports
- ☐ EKG
- ☐ Progress Notes
- ☐ Laboratory Reports
- ☐ Dental Records
- ☐ Operative Reports
- ☐ Radiology Reports
- ☐ Emergency Medicine Reports
- ☐ History & Physical Exams
- ☐ Diagnostic Imaging Reports
- ☐ Consultations
- ☐ Outpatient Clinic Records

☐ Other_____

***SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE***

_____

***SPECIFIC AUTHORIZATIONS***

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- ☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R §§2.34 and 2.35).
- ☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code *§§5328, et seq.)*
- ☐ I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code §120980(g)).
- ☐ I specifically authorize the release of genetic testing information (Health and Safety Code 124980(j)).

***THE PURPOSE OF THIS RELEASE IS (check one or more)***

- ☐ Continuity of care or discharge planning
- ☐ Billing and payment of bill
- ☐ At the request of the patient/patient representative
- ☐ Other (state reason)_____

***NOTICE***

Many organizations and individuals, such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

***MY RIGHTS***

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan for 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.

- 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:_____

  _____

- I am entitled to receive a copy of this Authorization.

A copy of this authorization is as valid as the original.

***EXPIRATION OF AUTHORIZATION;***

Unless otherwise revoked, this authorization expires _____ (*insert applicable date or event). If no date is indicated, this authorization will expire 12 months after the date of signing this form.*

***SIGNATURE***

_____ Date:_____

(Signature of Patient or Patient's Legal Representative)

_____ Time:_____ AM / PM

Printed Name

_____

(If signed by someone other than the patient, state your legal relationship to the patient/authority).

_____

Witness or Translator