FORM 16-1

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide *all* information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize_____
to release to:_____

_____

(Persons/Organizations authorized to *receive* the information) (Address—street, city, state, zip code)

the following information:

a. ❑ All health information pertaining to my medical history, mental or physical condition
and treatment received – ***OR***

❑ Only the following records or types of health information (including any dates):

_____

b. I specifically authorize release of the following information (check as appropriate):

❑ Mental health treatment information[1]

❑ HIV test results

❑ Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure: ❑ patient request; ***OR*** ❑ other:

_____

_____

_____

[1] If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

EXPIRATION

This Authorization expires [insert date]: _____

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.[2]

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: _____
_____.
My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.[3]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

If this box ❑ is checked, the Requestor will receive compensation for the use or disclosure of my information.[4]

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[2] If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[3] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see 45 C.F.R. Section 164.508(d)(1), (e)(2)).*

[4] The requestor is to complete this section of the form.

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

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient: _____

Witness: _____

AUTORIZACIÓN PARA UTILIZAR O DIVULGAR INFORMACIÓN MÉDICA

Al completar este documento autoriza la divulgación y el uso de su información médica. Esta autorización puede perder su validez si no proporciona *toda* la información solicitada.

USO Y DIVULGACIÓN DE INFORMACIÓN MÉDICA

Por medio del presente autorizo a _____

a divulgar a: _____
Personas u organizaciones autorizadas a *recibir* la información
Domicilio (calle, ciudad, estado, código postal)

la siguiente información:

a. ❑ Toda la información médica referente a mi historia médica, estado mental o físico y tratamiento recibido – ***O***

❑ Sólo los siguientes expedientes o tipo de información (incluso las fechas): _____

b. Autorizo específicamente la divulgación de la siguiente información (marque donde corresponde):

❑ Información sobre tratamiento de salud mental[1]

❑ Resultados de análisis de VIH

❑ Información sobre tratamiento de alcoholismo o drogadicción

Se requiere una autorización por separado para autorizar la divulgación o uso de las notas de psicoterapia.

OBJETIVO

Objetivo del uso o divulgación solicitados: ❑ solicitud de paciente; ***O*** ❑ otro:
_____
_____
_____

[1] If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented . The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

VENCIMIENTO

Esta autorización vence el [inserte la fecha]: _____

MIS DERECHOS

Puedo negarme a firmar esta autorización. Mi negativa no afectará mi calificación para obtener tratamiento o pago ni mi calificación para obtener beneficios.[2]

Puedo inspeccionar u obtener una copia de la información médica cuyo uso o divulgación se me solicita que autorice.

Puedo revocar esta autorización en cualquier momento, pero debo hacerlo por escrito y presentar mi revocación en este domicilio: _____ _____.

Mi revocación tendrá vigencia cuando se reciba, excepto en la medida en que otras personas hayan actuado basados en esta autorización.

Tengo el derecho de recibir una copia de esta autorización.[3]

El destinatario de la información divulgada en virtud de esta autorización puede volver a divulgarla. Dicha nueva divulgación en algunos casos no está protegida por la ley del Estado de California, y puede no estar protegida por la ley federal de confidencialidad (HIPAA).

Si este casillero está marcado ❑, el solicitante de la información recibirá compensación por el uso o divulgación de mi información.[4]

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[4] The requestor is to complete this section of the form.

FIRMA

Fecha: _____ Hora: _____ AM/PM

Firma: _____
(paciente, representante, cónyuge, tercero responsable en lo financiero)

Si la firma no pertenece al paciente, indique su relación legal con el paciente:

_____

Testigos:_____