



CONROI

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/Organization 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

HIV test results

Alcohol/drug treatment information

**PURPOSE**

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

**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. 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. 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).

Patient Name: \_\_\_\_\_

DOB \_\_\_\_\_

SSN \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_ am/pm

Signature: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
(parent/representative/spouse/financially responsible party)

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

Witness: \_\_\_\_\_



Community Hospital of the Monterey Peninsula®  
Post Office Box HH • Monterey, Ca. 93942 • Telephone (831) 624-5311

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**