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 ______________________________

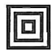
Date: ______________________________ Time: ______________________________ am/pm

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: ______________________________



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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

923630/8700 (10/04)

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