

AUTHORIZATION FOR USE OR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

This authorization for use or disclosure of my health information is required by state and federal law.

PATIENT'S NAME _____ DOB: _____
Last First MI

Daytime Telephone Number _____ Social Security No.: _____

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY MENTAL HEALTH INFORMATION

(NAME OF PERSON OR ORGANIZATION RELEASING INFORMATION)

STREET ADDRESS

CITY STATE ZIP CODE

TO RELEASE MY MENTAL HEALTH INFORMATION TO: *Check one: Send records Phone conference

(NAME OF PERSON OR ORGANIZATION RECEIVING INFORMATION)

STREET ADDRESS

CITY STATE ZIP CODE

THIS AUTHORIZATION APPLIES TO THE FOLLOWING MENTAL HEALTH INFORMATION:

- All records Lab Imaging Reports Immunizations
 Other _____

THE RECIPIENT MAY USE MY MENTAL HEALTH INFORMATION ONLY FOR THE FOLLOWING PURPOSE

(PLEASE SPECIFY)

A SPECIFIC AUTHORIZATION IS REQUIRED TO RELEASE INFORMATION REGARDING THE FOLLOWING:

*Important		YES	NO	INITIALS
Please check the "yes" or "no" boxes, then initial at the Xs.	HIV Information	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Drug/Alcohol Information	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Mental Health Information	<input type="checkbox"/>	<input type="checkbox"/>	_____

Restrictions: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

This authorization shall be valid until _____. Please indicate a date after which no information can be released. If no date is given, authorization is valid for 90 days only.

I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment.

I may revoke this authorization at any time, in writing. The revocation must be signed by me or on my behalf and sent to the address on the top of this form. The revocation is effective upon receipt but will have no impact on uses or disclosures made while the authorization was valid.

I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION. Copy Requested: Yes No Copy Received: Yes No

Patient Signature _____ Date _____

Patient/Personal Representative Signature _____

Relationship to Patient _____