AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____

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 _____ (initial)

   ❑ HIV test results _____ (initial)

   ❑ Alcohol/drug treatment information _____ (initial)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.[1]

(over)

1 Health care providers that do not maintain psychotherapy notes as defined in HIPAA may wish to delete this sentence.

PURPOSE

Purpose of requested use or disclosure: ❑ Patient request; OR ❑ Other:

_____

_____

_____

Limitations, if any: _____

_____

_____

EXPIRATION

This authorization expires on *(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[3] 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.[4]
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless

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 Patients of federally-assisted substance abuse programs and patients whose records are covered by LPS may revoke an authorization verbally.

4 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(c)(4))*.

another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Date: _____ Time: _____ ❑AM - ❑PM

Signature: _____
(patient/legal representative)

If signed by a person other than the patient, indicate relationship: _____

Print name: _____
(legal representative)

NOTES FOR PROVIDERS THAT USE THIS FORM:

- If the purpose of the authorization is to use the information for marketing by a third party that remunerates the provider, a statement to this effect must be included in this authorization form.
- If the purpose of the authorization is for the sale of protected health information (PHI), this form must state whether the PHI can be further exchanged for remuneration by the initial recipient.
- A provider that discloses health information pursuant to an authorization must communicate any limitation contained in the authorization to the recipient [Civil Code Section 56.14]. The required notification may be accomplished by giving the recipient a copy of the authorization form.

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.

Nombre del paciente: _____

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 _____ (inicial)

   ❑ Resultados de análisis de VIH _____ (inicial)

   ❑ Información sobre tratamiento de alcoholismo o drogadicción _____ (inicial)

Se requiere una autorización adicional para permitir la divulgación o el uso de notas de psicoterapia, según se define en las regulaciones federales de la Ley de Portabilidad y Responsabilidad de Seguros Médicos.[1]

(sobre)

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OBJETIVO

Objetivo del uso o divulgación solicitados: ❑ Solicitud de paciente; O ❑ Otro:

Limitaciones, si existen:

VENCIMIENTO

Esta autorización vence el *(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[3] 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.[4]
- El destinatario de la información divulgada en virtud de esta autorización puede volver a divulgarla. Dicha nueva divulgación en algunos casos no es +prohibido por la ley del Estado de California, y puede no estar protegida por la ley federal de confidencialidad

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(HIPAA). Sin embargo, la ley de California prohíbe que la persona que recibe la información sobre mi salud la revele, a menos que yo autorice dicha revelación o que ésta sea requerida por la ley o permitida por ésta.

FIRMA

Fecha: _____ Hora: _____ ❑AM / ❑PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

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