Authorization for Use or Disclosure of Health Information

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

Name of patient: _____ Date of birth: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: _____
(Persons/organizations authorized to receive the information)

To have access to the following health information (*check only **one** box*):

a. ❑ Any and all health information pertaining to my medical history, mental or physical condition and treatment received, other than psychotherapy notes*, including, but not limited to, authorizations, lab records, claim records, mental health records protected by the Lanterman-Petris-Short Act, if any, drug and/or alcohol abuse and treatment records, if any, genetic test results, if any, and/or HIV test results, if any, except as specifically provided below (include any date limitations as you require): _____

_____

b. ❑ All psychotherapy notes, except as specifically provided below*: _____

_____

*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.

PURPOSE

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

_____

_____

_____

Limitations, if any: _____

_____

Requested Format: ❑ Paper ❑ Verbal ❑ Secure email ❑ Other: _____

EXPIRATION

Unless otherwise revoked, this authorization expires on (date): _____/_____/20_____.

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: Attention: Customer Service, 8510 Balboa Blvd., Suite 150, Northridge, CA 91325.
- My revocation will take effect upon receipt. My revocation will not affect actions that Lakeside Community Healthcare has already taken in reliance upon this authorization prior to receipt of the revocation in writing.
- 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 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 another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Date: _____ Time: _____

Signature: _____

(Patient/legal representative)

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

Print Name of Signer: _____

(Patient or legal representative who signed above)

*Prior to accepting this form, identification to positively identify patient or, if a legal representative, then ID for representation and documentation affirming their authority to sign this authorization on behalf of patient (attach documentation).