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(Facility Name and Address)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Consumer's Name:

Birthdate:

Address:

I authorize:

(Name or Person and/or Facility which has information/records)

(Street Address, City, State, Zip Code)

to release health information and records to:

(Specify Name/Title of Person and/or Facility to receive information/records)

(Street Address, City, State, Zip Code)

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Please specify the health information you authorize to be released:

☐ **MEDICAL** ☐ **DENTAL** ☐ **MENTAL HEALTH** (other than psychotherapy notes)

Types(s) of health information:

Date(s) of treatment:

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. Section 2.34 and 2.35).

☐ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code Section 120980(g)).

☐ I specifically authorize the release of genetic testing information (Health and Safety Code Section 124980(j)).

The purpose of this release is for (check one or more):

☐ At the request of the consumer or consumer's legal representative

☐ Other (state reason)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Consumer's Name:

Birthdate:

Address:

NOTICE

and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your representative, and delivered to:

(Name and Mailing Address)

The revocation will take effect when receives it, except to the extent or others have already relied on it. You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____________________________ _____________________________

Print Name | Signature (Patient, Parent, Guardian)

_____________________________ _____________________________

Date | Time | Relationship to Patient (Parent, Guardian, Conservator, Patient Representative

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Witness (only if patient unable to sign) or Interpreter