Authorization for Use or Disclosure of Personal Health Information

Patient Name: _____ Patient DOB: _____

EXPLANATION

This form is to allow the use of your medical information. It follows the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

AUTHORIZATION

By this I authorize (name of physician, hospital or health care provider):

_____

To provide to (name of requestor):

_____

Medical records and information referring to medical history, mental or physical condition, services provided, or treatment of (name of patient): _____

This authorization is limited to the following medical records and information:

_____

_____

USES

The requestor may use the approved medical information only for the following purposes:

_____

_____

DURATION

This authorization is effective immediately. It will remain in effect until (date): _____
I understand that any requests to revise or cancel must be in writing.

RESTRICTIONS

The requester may not share the health information without another written approval. Further use may occur if law specially requires it. Consent to treatment is not based upon signing this document.

ADDITIONAL COPY

I am aware that I have a right to receive a copy of this document by requesting it.

Copy requested and received _____Yes _____No Initial _____

SIGNATURE

Date: _____ Time: _____ AM / PM

Printed Patient Name: _____ Patient DOB: _____

Signature: _____

If signed by another individual, indicate relationship to patient: _____ Witness: _____