



### Authorization for the Use or Disclosure of Health Information

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. I authorize \_\_\_\_\_ to disclose of my health information to:  
Name: \_\_\_\_\_  
Address or fax #: \_\_\_\_\_

2. This authorization applies to [check one box]:

Only the following records or type of information or specific dates of treatment [circle desired records]:

- labs
- chart notes
- imaging
- other: \_\_\_\_\_

**All health information** pertaining to any medical history, mental or physical condition and treatment received. Includes information related to drug, alcohol and/or psychiatric conditions or conditions pertaining to sexually transmitted diseases including AIDS. HIV test result information will NOT be released unless specifically requested (sign in box below if you wish to release this information).

Exclusions: \_\_\_\_\_  
\_\_\_\_\_

Please release my HIV test results to the recipient listed in item #1.

Signed: \_\_\_\_\_ Dated: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. The receiver may use the medical information that is being released for the following purposes (if you do not want to explain the purpose, write "At the request of the individual."): \_\_\_\_\_  
\_\_\_\_\_

4. This authorization expires on date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Your Rights

- I know that I may revoke this authorization to the extent that it has not already been relied upon. I may revoke this authorization by writing a statement that I withdraw my authorization for further release of the records.
- Any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules; however, California law prohibits the receiver from making further disclosure of my health information unless the receiver obtains another authorization from me or unless such disclosure is specifically required or permitted by law.
- I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to assure treatment unless the sole purpose of the treatment/examination/evaluation is to provide information to a third party.
- I have a right to receive a copy of this authorization.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_

If not signed by the patient, please indicate the relationship: \_\_\_\_\_