neighborhood HEALTHCARE

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Instructions to complete an Authorization for Use or Disclosure of Health Information.

Section I: Explanation

1. Patient Name
2. Date of Birth

Section II: Use and Disclosure of Health Information

1. Name, address, phone number, and fax number of the facility authorized to release records.
2. Name, address, phone number, and fax number of the facility authorized to receive records.

Section III: Information to be Released

1. Description of Information to be released including timeframes if applicable. If no timeframe is included, only 6 months of records will be released.

Section IV: Authorization to Release Statutorily Protected Information. Patient Initials and Behavioral Health Provider Approval.

If patient is requesting Mental Health Treatment Information: Psychiatric, or Psychotherapy Notes, Labs performed during mental health visits, HIV Test results, or Alcohol/Drug Treatment Information, patient must initial appropriate boxes prior to releasing.

Section V: Purpose of Requested Use or Disclosure

The purpose for releasing the records. For example, continuity of care, patient use, legal purposes, etc.

Section VI: Expiration Date

Expiration date for when authorization is no longer valid. If no expiration date is given, authorization will expire 12 months from signature date.

Section VII: My Rights

This section explains the patient's rights and responsibilities. Patient should review carefully prior to signing.

1. **Revocation of an Authorization –** Patient has the right to revoke an existing authorization at any time but must do so in writing.
2. Patient has the right to request and receive a copy of Authorization. Patient should select Yes or No, initial and date.

Section VIII: Signature

1. Signature of patient or guardian/legal representative and, if necessary, relationship to the patient.
2. Date of Signature.

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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

EXPLANATION

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Name of Patient:	
Date of Birth:	Medical Record #:

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby Authorize:

Name/Facility:			Attention:
Address:			Phone:
City:	State:	Zip:	FAX:

To release my records to: Neighborhood Healthcare:

Address:			Phone:
City:	State:	Zip:	FAX:

INFORMATION TO BE RELEASED

☐ **Pertinent Information (This is what most physicians need):** Clinic problem list, immunizations, Progress Notes, Labs, Radiology.

☐ Hospital discharge summary and specialists' consultations for hospitalization from _____

☐ ER Physician's dictated notes and diagnostic imaging reports & specialists' consultations from _____

☐ All prenatal records

OR ☐ Other - please be specific_____

The Date of Service I am requesting is from _____ to _____

*****If no date is entered only 6 months will be released**

AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION

I specifically authorize release of the following information (check and initial as appropriate):

	Patient Initial	Behavioral Health Provider Signature
☐ Mental health treatment information		
☐ Psychiatric Progress Notes		
☐ Therapy Notes		
☐ Labs		
☐ HIV test results		
☐ Alcohol/drug treatment information		

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PURPOSE

Purpose of requested use or disclosure:

☐ Patient Request ☐ Continuing Care ☐ Legal
☐ Insurance ☐ Other _____

EXPIRATION

This Authorization expires [insert date]:_____
If no Date is given; this authorization will expire 12 months from the signature date.

MY RIGHTS

I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. 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:

Name/Facility:	Attention:
Address:	Phone:
City: State: Zip:	FAX:

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.

Copy requested and received:

☐ Yes ☐ No	Initial:	Date:

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

Patient Signature:	Date:
Legal Representative Signature: (Patient representative/spouse/financial responsible party)	Date:
If signed by someone other than the patient, state your legal relationship to the patient and why you have the authority to act for the patient:	
Witness Signature:	Date:
Reviewed with the requestor: _____ _____ Name Signature	Date: