

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_ to  
 (Name of individual) (Name of person or facility which has information)

release the following health information:

To:

(Name of person/title or facility to receive health information)

(Street address, city, state, ZIP code)

(Telephone number)

(Fax number)

For the purpose of: \_\_\_\_\_

This authorization is in effect until \_\_\_\_\_ (date or event) when it expires.

**I understand that by signing this authorization:**

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

**I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION  
ON THIS FORM IS TRUE AND CORRECT.**

SIGNATURE	DATE
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**IDENTIFYING INFORMATION**

COPY OF IDENTIFICATION ATTACHED

TYPE \_\_\_\_\_ (CA DRIVER'S LICENSE, CA DMV  
IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY  
IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL  
EMPLOYEE ID CARD)

NUMBER \_\_\_\_\_

**IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE  
NOTARIZED.**

NOTARIZED BY \_\_\_\_\_

ON \_\_\_\_\_ (DATE)

NOTARY PUBLIC NUMBER \_\_\_\_\_

**UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC**