



HSA MR#: \_\_\_\_\_

### AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION

This Authorization for use or disclosure of my health information is required by State and Federal law. Failure to provide all information may invalidate this Authorization. A copy of this signed Authorization will be considered as valid as the original.

#### PATIENT INFORMATION (Print)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I authorize my health information to be released FROM:

Clinic or Doctor: \_\_\_\_\_  
Address: \_\_\_\_\_  
Ph #: \_\_\_\_\_ Fax #: \_\_\_\_\_

I authorize my health information to be released TO:

Clinic or Doctor: \_\_\_\_\_  
Address: \_\_\_\_\_  
Ph #: \_\_\_\_\_ Fax #: \_\_\_\_\_

PURPOSE OF DISCLOSURE:  Continue health care  Other \_\_\_\_\_

INFORMATION TO BE RELEASED: specify dates \_\_\_\_\_

- Complete Medical Record
- Lab
- X-ray
- Labor & Delivery
- Other \_\_\_\_\_

Special consent is required to release the following: (Pt. Initial) (Date)

- Mental Health \_\_\_\_\_
- Drug/alcohol \_\_\_\_\_
- HIV test results \_\_\_\_\_

This Authorization shall become effective immediately and shall remain in effect (not to exceed 6 mo.)  6 months from date of signing  Other \_\_\_\_\_

*Completion of this document and acknowledgement of the back of this document authorizes disclosure and/or use of my health information.*  
**NOTE: PLEASE READ THE BACK OF THIS FORM BEFORE SIGNING.**

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

\*If signed by someone other than the patient, state name and relationship below:

Employee Processing Request: \_\_\_\_\_ Date: \_\_\_\_\_

Identification Verified with: \_\_\_\_\_

HSA MR#: \_\_\_\_\_

## Authorization for Use and/or Disclosure of Health Information - Page 2

**NOTICE OF RIGHTS AND OTHER INFORMATION**

- I may refuse to sign this Authorization
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or my representative, and delivered to the Health Services Agency. The Notice of Privacy Practices provides instructions on how to revoke my authorization.
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this Authorization.
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.
- Information disclosed pursuant to this Authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law. However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose, if this authorization is initiated by the Health Services Agency.