Stanislaus County HEALTH SERVICES AGENCY

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: _____

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.