Authorization for Use and/or Disclosure of Patient Health Information

Leave Blank, for office use only

I hereby authorize:

_____

To Disclose to:

_____

or to their representative;

Records and information pertaining to:

_____

(Patient Name)

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524

Duration: This authorization shall become effective immediately and shall remain in effect until _____ or three years from the date of signature.

Re-disclosure: 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). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 CFR part 2.

Revocation: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written 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 understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

GINA: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact than an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I understand that this release does not constitute a request or requirement by the covered entity for the release of any genetic information in connection with the release of any medical information. I understand that to comply with the requirements of GINA, the covered entity will ask that any individual or entity providing medical information pursuant to this release not provide any genetic information when responding to any request for medical information. Any genetic information provided in response to any request will be deemed inadvertent.

Records to be Released:

☒ Medical Information

☐ Psychiatric Information

_____
(Signature) (Date)

☐ Drug \ Alcohol Information

_____
(Signature) (Date)

☒ Other Information (Specified below)

Specifying the other records to be disclosed: Any and all records, including but not limited to: diagnosis, testing, treatment, in patient or out patient records, any correspondence, computerized records, billing records or any other documents under your custody and control.

Purpose: The requestor may use the information authorized on this form for the following purpose only: To investigate the patients claim of injury.

A copy of this Authorization is as valid as the original.

The signer / patient has a right to a copy of this Authorization.

Date: _____

Signature: _____

Date of Birth:_____