Authorization to Use or Disclose Protected Health Information

* For the verification of identity you must provide Driver's License, Passport, ID card, etc.

A →Patient Name__________ Date of Birth__________ CHP ID__________
Address__________ City__________ State__________ Zip__________
Verification of Identity*__________ Phone Number__________

If you are not the patient and you are authorizing the disclosure *of the protected health information for the above named patient,* ***complete this section****.* (**Leave blank if you are the patient**.)
Your Name__________ Relationship to the Patient__________
Legal Authority__________ Verification of Authority__________
Verification of Identity*__________ Witness__________

B→By signing this form, I__________ authorize__________ to release the following protected health information:
____

I further authorize the disclosure of information related to: (check all that apply)	*I further authorize the disclosure of:* (check all that apply)
☐ Mental Health Conditions or Treatments ☐ Substance/Alcohol Abuse ☐ HIV/Aids ☐ Other Sexually Transmitted Diseases ☐ Genetic Disorders	☐ Records created by other health care providers not associated with the organization or entity above, which may be included in the health information described. ☐ Records of the same type listed above for disclosure, created after today's date, until the expiration date shown below or six (6) months from the date this authorization, whichever comes first.

C →*Please release my protected health information to*:
Name__________ Phone Number__________
Address__________ City__________ State__________ Zip__________

D → I understand that once information is disclosed, the information is subject to re-disclosure and may no longer be protected by federal privacy regulations. I hereby release (the facility) and its employees from any and all liability that may arise from the release of information as I have directed. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Dept. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my health plan when the law provides my plan with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in six (6) months from the date signed below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment. I understand I may inspect or copy the information used or disclosed as provided in CFR164.524. If I have questions about disclosure of my health information I can contact Medical Records, Member Services or the Privacy Officer.

E →Signature of Patient or Legal Representative__________
Date__________ Expiration Date__________
(otherwise the expiration will be six months from the date indicated above)

Revision History
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