

Completion of this document authorizes the disclosure and/or use of health information about you.

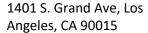
Failure to provide all information requested may invalidate this authorization.

PATIENT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient:	_Date of Birth:
Other Names Used:	Telephone Number:
I authorize:	CALIFORNIA HOSPITAL
(Facility or other	er provider)
To disclose to:	ns authorized to receive the information)
(Persons/organization	is authorized to receive the information)
at the following address:	(street, city, state and zip code)
	(street, city, state and zip code)
The following information contained in applicable lines below):	the records specified below (check box and initia
 "psychotherapy notes.") Substance abuse treatment reco HIV test results (This authorizes) 	s disclosure of laboratory test results only). clude information concerning your HIV status
THE FOLLOWING RECORDS, specified (checked) of treatment as specified (checked)	fic types of health information, or records for the ck applicable box(es)]:
☐ Itemized Billing Records☐ Complete Health Record(s)☐ History and Physical☐ Consultation Record	Emergency Room RecordsProgress NotesLaboratory TestsRadiology Reports



Dates of Service (Please specify date range)
ALL RECORDS regarding my treatment, hospitalization, and outpatient care. A separate authorization is required for the use and disclosure of psychotherapy notes or research health information.
PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is
AT the request of the patient or personal representative, OROther:
EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified:
(Insert date)
 I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:
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 C.F.R. part 2.
SIGNATURE:Date:Date:
(Patient or personal representative)
Print name of personal representative Relationship to patient
Patient/Representative Identification Verified. Initials:Dept:





Note: If the **substance abuse treatment** information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.