Live Well. Health Matters.

AUTHORIZATION FORM FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____

Client Name

_____ _____

Record/Account Number Date of Birth

_____ _____ _____

Street Address City, State, Zip Code Phone

Check One Option Below:

[ ] I, the undersigned, hereby authorize Beach Cities Health District to use and/or disclose the above-named client's protected health information to the following health care provider, person, or agency.

[ ] I, the undersigned, hereby authorize Beach Cities Health District to obtain the above-named client's protected health information from the following health care provider, person, or agency.

Note: Beach Cities Health District may release or obtain the above-named individual's protected health information in either verbal and/or written form.

_____

Name of Health Care Provider, Person, or Agency

_____ _____

Street Address City, State, Zip Code

_____ _____

Phone Fax (if needed)

Purpose for release of information:

[ ] Diagnostic Summary **[ ]** Legal **[ ]** Payment/Insurance

[ ] Educational/Employment/Social Services **[ ]** Personal Use (*only the client can check this box*)

[ ] Other:_____

Provide the records by means of: [ ] Mail **[ ]** Email **[ ]** Fax **[ ]** Pick-up

Specific Information to be Released (please initial information to be released):

A. Medical Record [ ] All health information (e.g., diagnosis, test results, treatment); OR [ ] Images and / or Films [ ] Reports [ ] Dental	**Initial:**
B. Lab Requisition Form/Collection Details Form / Laboratory Results	**Initial:**
C. HIV / AIDS*	**Initial:**
D. Drug & Alcohol Treatment / Substance Abuse Records	**Initial:**
E. Mental Health / Behavioral Health / Psychotherapy Notes**	**Initial:**
F. Other: (Name, email, phone number, age, gender, preferred language, allcove health surveys)	**Initial:**
G. FPACT information	**Initial:**
H. Billing Records	**Initial:**
I. Order or Referral Forms	**Initial:**
J. Sexually Transmitted Disease Records	**Initial:**
K. Tuberculosis Records	**Initial:**
L. Genetic Testing Information Records	**Initial:**
M. Summary of Record Set	**Initial:**
N. Entire Designated Record Set	**Initial:**

[ ] Other:_____

From:_____ To:_____
(Date range of records needed from) (Date range of records needed to)

*** HIV/AIDS: A separate authorization is required for each disclosure.**
****Psychotherapy Notes: An authorization for use or disclosure of psychotherapy notes may not be combined with authorization for release of other protected health information. If requesting the use or disclosure of psychotherapy notes, please only check psychotherapy notes above and complete a separate form for any other information being requested.**

Certain sensitive medical record information is afforded a higher level of confidentially by state and federal law. Beach Cities Health District will not release the records described below unless you initial the line next to each type of record you wish to be released.

Part 2 Requirement: If substance use records, you want to specify how much and what kind of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed. Please specify in the box below.

Part 2 Requirement: The purpose of the disclosure (the disclosure must be limited to the information which is necessary to carry out t the stated purpose). Please complete the box below.

[ ] Treatment related to Substance Abuse

[ ] Payment related to Substance Abuse

[ ] Health Care Operations related to Substance Abuse

[ ] Other _____

[ ] Disclosure to Central registry or to any withdrawal management or maintenance treatment program

Please specifically describe the purpose:

Part 2 Requirement: For substance use records, please specify the date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is provided. Please specify in the box below.

▪ REVOCATION: I understand that I have the right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to the Beach Cities Health District Privacy Officer. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to process a claim under my policy. Further, I understand that actions taken in reliance on this authorization cannot be reversed, and my written revocation will not affect those actions. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer.

▪ REDISCLOSURE: Information disclosed pursuant to this authorization could be redisclosed by the recipient. Once this information is released, it may not be protected under federal privacy law (HIPAA). State or federal law may require the recipient to obtain your authorization before further disclosure. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA), although information protected by 42 CFR Part 2 continues to be subject to that protection. In addition, 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.

▪ DURATION OF AUTHORIZATION: **THIS AUTHORIZATION WILL EXPIRE WITHIN** (insert #(s) years/months) _____ of the date of execution or if the following event or condition occurs:_____ . The consent will last no longer than reasonably necessary to serve the purpose for which it is provided. If I do not write in a date or event, my authorization will expire twelve months from the date it was signed.

▪ FEES: I understand that there *may* be fees associated with re-disclosures, excluding for direct client care (*i.e.*, practitioner to practitioner communication). If advance notice of cost is desired, **PLEASE INITIAL HERE**: _____; otherwise you will be billed for this service. After you receive notice of any applicable charges, you may cancel this request without charge.

▪ I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment; or eligibility for benefits unless allowed by law. I understand that I may inspect the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of

information carries with it the potential for unauthorized re-disclosures and the information may not be protected by federal confidentiality rules.

By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____	_____
Patient Name	Date
_____	_____
Patient Signature	Date
_____	_____
Authorized Representative Name	Date
_____	_____
Authorized Representative Signature	Date

If signed by a personal representative, a description of the representative's authority to act on behalf of the client is as follows:

[ ] Legal Guardian
[ ] Power of Attorney
[ ] Next of Kin Deceased
[ ] Executor of Estate