AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

ochealth CARE AGENCY

FOR OFFICE USE ONLY	PART 1: CLIENT/PATIENT INFORMATION			
	Client/Patient Last Name	Client/Patient First Name		Middle Initial
	Other Names Used	Date of Birth	SSN (Last 4 Digits)	MRN (If known)
	Email:	Telephone Number with area code:		
	Address	City	State	Zip

PART 2: THE HEALTH CARE AGENCY MAY DISCLOSE THIS INFORMATION TO: ☐ Check if same as above

Name of Person or Organization			Address
General Designation *(For 42 CFR Programs only)*			
City	State	Zip	Telephone Number with area code

PART 3: PURPOSE OF THIS AUTHORIZATION

☐ Patient Request ☐ Continuity of Care/Medical Treatment ☐ Insurance ☐ Legal ☐ Disability
☐ Other:

PART 4: INFORMATION THAT CAN BE RELEASED (Steps 1, 3, and 4 required. Complete step 2 for specificity)

Step 1. Select one only: ☐ Medical Records ☐ Summary of Treatment

Step 2. Select types of records to be released:

☐ Family Health ☐ STD Treatment ☐ California Children's Services (CCS)
☐ X-ray Results/Films ☐ Pulmonary/TB ☐ WIC ☐ Immunizations
☐ AMM/MSN/MSI ☐ Dental Care ☐ Other:

Your *initials* and *date range* of records to be released are ***required*** below for use or release of the following types of sensitive information or records:

	Alcohol, Drug or Substance Abuse Records**	Date From:	Date To:
	Mental Health	Date From:	Date To:
	HIV/AIDS Testing and Results	Date From:	Date To:

Step 3. Clinic(s) where services were received:

Step 4. Delivery Preference: ☐ Electronic ☐ Mail ☐ Pickup

FOR YOUR REVIEW

I have read the contents of this form. I understand, agree, and allow the County of Orange to use and release my information as I have stated above. I also understand that signing this form is voluntary and treatment, payment or eligibility for benefits will not be affected if I do not sign this authorization. I have the right to revoke this authorization at any time in writing by sending a notice to the Custodian of Records. The revocation will not affect disclosures the Custodian has already taken action in reliance on the authorization. Information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by federal privacy law (HIPAA). Applicable State or other federal law may require recipient to obtain your written authorization before re-disclosure unless otherwise permitted by such laws. I am entitled to a copy of this form. Fees may apply to certain requests. A copy of the original authorization is valid. This authorization expires upon completion of this request.

PART 5: Client/Patient Signature or Designated Legal Representation/Guardian Signature	PART 6: Date
X	
Legal Representative (print full name)	Legal relationship to client/patient

** ALCOHOL AND SUBSTANCE ABUSE INFORMATION

42 CFR part 2 prohibits unauthorized disclosure of these records.

Please return completed form for processing to: HCA Custodian of Records ● 200 W. Santa Ana Blvd., Suite 180, Santa Ana, CA 92701 ● Phone (714) 834-3536 ● Website: http://ochealthinfo.com/records ● COR@ochca.com

For Use for Medical Records Request from Custodian of Records

***All numbered items must be completed for authorization to be valid**