AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

PART 1: CLIENT/PATIENT INFORMATION

Client/Patient Last Name	Client/Patient First Name	Middle Initial	Date of Birth

Other Names Used	SSN (Last 4 Digits)	MRN	Address

City	State	Zip	Telephone Number with area code

PART 2: PERSON OR ORGANIZATION WHO WILL **DISCLOSE** THIS INFORMATION

Name of Person or Organization	Address

City	State	Zip	Telephone Number with area code

PART 3: PERSON OR ORGANIZATION WHO WILL **RECEIVE** THIS INFORMATION

Name of Person or Organization	Address

General Designation *(For 42 CFR Programs only)*

City	State	Zip	Telephone Number with area code

PART 4: PURPOSE OF THIS AUTHORIZATION

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

PART 5: INFORMATION THAT CAN BE RELEASED *(Section A required, B&C if required and/or applicable)*

A. *Check only one box:* ☐ Medical Record PHI ☐ Summary of PHI

B. *Check appropriate boxes for type of information to be released:*

☐ Lab/Test Results ☐ WIC ☐ AMM/MSN/MSI ☐ Child Health/Immunization Records
☐ Maternal Health ☐ Pulmonary/TB ☐ X-ray Films ☐ California Children's Services (CCS)
☐ STD Treatment ☐ Dental Care ☐ X-ray Results ☐ Other:_____

C. *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:**

PART 6: DATE YOUR AUTHORIZATION EXPIRES

Unless otherwise revoked in writing, this authorization expires: ☐ Upon completion of this request **OR**
☐ Upon date, event or condition specified: _____

If no date, event, or condition is indicated, this Authorization will expire 12 months after the date of signing this form

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.

PART 7: Client/Patient Signature or Designated Legal Representative/Guardian Signature	PART 8: Date
X	

Legal Representative (print full name)	Legal relationship to client/patient		

Legal Representative Street Address	City	State	Zip

** ALCOHOL AND SUBSTANCE ABUSE INFORMATION

The information disclosed to the recipient is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit the recipient of this information from re-disclosing the information unless it is expressly permitted by the written consent of the patient or as otherwise permitted by 42 CFR 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. You have a right pursuant to §2.13(d), that upon your request you must be provided a list of entities to which your information has been disclosed pursuant to a general designation on this consent form.