



OAKLAND LEGAL OFFICE
433 Hegenberger Rd. Suite 220 Oakland Ca. 94621-1448
Telephone: (510) 430-8033 Fax: (510) 430-8246
Toll Free/TTY/TDD: (800) 776-5746
www.pai-ca.org

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

NOTE: Your protected health information can be disclosed only if this authorization form is completely filled out and is dated and signed. *See*, Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 C.F.R. § 164.508(b)(2)(ii), 164.501; Cal. Civil Code § 56.11, 56.05(f)

I, (name of patient/client) _____, authorize:

Name/Organization providing information _____

Address (optional) _____

to release my health information (as described below) to:

Name/Organization receiving information _____

Address _____

Description of the health information to be disclosed, including (as needed) specific identification of the information such as type of record, date(s) or range of dates. *See*, 45 C.F.R. §§ 164.508(c)(1)(i). (A separate authorization form must be used for disclosure of psychotherapy notes.) *See*, 45 C.F.R. 164.508(b)(3)(ii), 164.501 (definition of “psychotherapy notes”):

Description of each purpose for which my health information is to be disclosed or used (e.g. “for legal representation”). (If you choose not to provide a more specific description of the purpose, you may state “at the request of the individual” in the space below.) *See*, 42 C.F.R. § 164.508(c)(1)(iv), 164.501:

- I understand that if my protected health information is further disclosed by the recipient of the information, it might no longer be protected under federal health information privacy regulations or California medical information privacy laws, unless it is disclosed to a health care provider or health plan. See, 45 C.F.R. §§ 164.508(a)(1), 164.508(c)(2)(iii), Cal. Civil Code § 56.13. However, other confidentiality requirements may protect my health information from disclosure.
- I have had the opportunity to read and consider this authorization. This authorization is voluntary on my part and has been approved by me.
- I understand that I may revoke this authorization at any time by writing to the provider(s) of the health information named above, except that I cannot revoke this authorization to the extent that any health care provider or health plan named above has taken action in reliance on this authorization. (If I am a nursing home resident, any revocation must be signed in the presence of a representative of Protection & Advocacy, Inc. in order for the revocation to be valid.)
- I understand that I have a right to receive a copy of this authorization.

A photocopy or facsimile of this authorization may be used in place of the original.

This authorization expires on _____.

Signed: _____ **Date:** _____

Name(s) of person(s) signing _____

Relationship or authority of person signing (only if signed by personal representative, e.g. parent, guardian, conservator, health care agent). See, 45 C.F.R. §§ 164.508(c)(1)(vi), 164.502(g): _____

Date of Birth of Patient/Client (optional, but important for identification): _____

This authorization form must be used for disclosure of health information by a health care provider or health plan. 45 C.F.R. §§ 164.508(a), 160.103, 164.50; Cal. Civil Code §§ 56.10(a), 56.11, 56.05, 56.13.

“*Health information* means any information, whether oral or recorded in any form or medium, that: (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.” 45 C.F.R. § 160.103.