Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____

I authorize _____ to release my (my child's) confidential health information as indicated by the checkmark(s) below to:

_____

Provider or facility

Phone: _____ Fax: _____

☐ Entire File ☐ Oral Communication ☐ Email Communication

☐ Diagnosis ☐ Treatment Plan ☐ Dates of Treatment

☐ Other: _____

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.

I understand that Provider cannot condition treatment upon me signing this authorization.

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

Provider is authorized to disclose the protected health information specifically listed above until: _____

☐ Check this box to make this release of information reciprocal with the provider named above.

_____ _____

Client or legal guardian Signature Date

_____

Printed Name