# AUTHORIZATION FOR RELEASE OF INFORMATION (Template)

| **Your Information** | | |
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| Last Name: | First Name: | Middle Initial: |
| Address: | City/State: | Zip Code: |

| **Person/Organization Providing the Information** | **Person/Organization Receiving the Information** |
| --- | --- |
| Name:  Position or Role:  Address:  City/State/Zip:  Phone # : ( )  Fax #: ( ) | Name:  Position or Role:  Address:  City/State/Zip:  Phone # : ( )  Fax #: ( ) |
| *45 C.F.R. §§ 164.508(c)(1)(ii), and (iii); CA Civil Code §§ 56.11(e), and (f)* | |

| **Description of the Information to be Released**  **(Provide a detailed description of the specific information to be released)** | |
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| *45 C.F.R. § 164.508(c)(1)(i); CA Civil Code §§ 56.11(d), and (g)* | |
| **Check each type of confidential information you authorize to be released:** | |
| HIV or AIDS Information  Alcohol/Drug Information Health Information | Mental Health/Behavioral  Genetic Testing |

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| Other: |
| For the following period of time: from\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) to\_\_\_\_\_\_\_\_\_\_\_\_\_ (date). |

| **Description of the Purpose and Limitations for the Use or Release of the Information (Indicate how information will be used)** |
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| *45 C.F.R. § 164.508(c)(1)(iv); CA Civil Code § 56.11(g)* |
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| The information will not be used for any purpose other than its intended use. |

| Will the health plan or provider receive money for the release of this information? |
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| *45 C.F.R. § 164.524(c)(4)* |
| Yes  No |
| Reasonable fees may be charged to cover the costs of copying and postage. |

This authorization for release of the above information to the above named persons or organizations will expire on:       (date).

*[45 C.F.R. § 164.508(c)(v); CA Civil Code § 56.11(h)]*

I understand that:

* I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. *[45 C.F.R. § 164.508(c)(2)(i)]*
* I have the right to revoke this authorization at any time by sending a signed   
  notice stopping this authorization to   
  at . The authorization will cease on the date my valid revocation request is received.
* *[45 C.F.R. § 164.508(c)(2)(i); CA Civil Code § 56.15]*
* The Notice of Privacy Practices provides instructions for me should I choose to revoke my authorization and includes limitations on my revocation*.*
* *[45 C.F.R. § 164.508(c)(2)(i)]*
* My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization. *[45 C.F.R. § 164.508(c)(2)(ii)]*
* Under California law, the recipient of my medical information is prohibited from   
  re-disclosing the information, except with a written authorization or as specifically required or permitted by law. *[CA Civil Code § 56.13]*
* If the organization or person I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. *[45 C.F.R. § 164.508(c)(2)(iii)]*
* I have the right to receive a copy of this authorization.

*[45 C.F.R. § 164.508(c)(4); CA Civil Code § 56.11(i)]*

* Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes. *[CA Civil Code § 56.104(a)(4)]*

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| Patient Signature: | Date: |

*[45 C.F.R. § 164.508(c)(1)(vi); CA Civil. Code § 56.11(c)]*

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| Patient’s (Personal) Representative Signature: | Relationship: | Date: |

*[45 C.F.R. § 164.508(c)(1)(vi); CA Civil Code § 56.11(c)]*