AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

In accordance with California Law and the HIPAA Privacy Rule, when PHI is to be used or disclosed for purposes other than treatment, payment, or health care operations, the Facility will use and disclose it only pursuant to a valid, written authorization, unless such use or disclosure is otherwise permitted or required by law. Inspection must be permitted within five (5) working days and copies provided within fifteen (15) calendar days after the written request is received. This can be extended to thirty (30) calendar days. If this extension will be needed, you will be notified. Please read each section carefully and complete the required sections before signing. Please clearly and legibly print all information and sign on the last page. Incomplete requests will not be processed.

SECTION A:
Patient's name: Last: _____ First:_____ MI: _____

Date of birth:_____ Phone number:_____Medical Record Number: _____

SECTION B:

YOU AUTHORIZE**:** **Centric Health /** _____

TO DISCLOSE TO: _____
(Persons/organization authorized to receive the information)

at the following address: _____
(Street, City, State and Zip Code)

SECTION C: Please describe the specific health information you would like released by completing the appropriate information below. *Provide (date(s) of care and specific record type(s) provider name (s) if applicable.*

C.1: <u>General Health Information Release</u>

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history including: (check below)
  - ❑ Sexually transmitted disease,
  - ❑ Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
  - ❑ Behavioral or mental health services and treatment for alcohol and drug abuse.
- ❑ Only the following records or types of health information_____
  _____

SECTION D: You would like this information released in the following format: *(Select <u>one</u> of the following)*

- ❑ Paper Copy
- ❑ Electronic PDF File (Patient requests only)
- ❑ Review in Office – *Staff will not be available to answer medical questions*

You would like this information released via the following method: *(Select <u>one</u> of the following)*

- ❑ Mail
- ❑ Pick up in person (Date): _____ (15 working days)
- ❑ Fax (Continued Care Requests Only) Provide Fax number: _____
- ❑ Secure Email (Patient requests only) Provide Email address:

SECTION E:
Please indicate the reason you would like your health information released._____

❑ Check here if you are the patient and you do not want to provide the reason.

SECTION F: EXPIRATION:
I understand that this Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of _____, 20_____.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs: _____

SECTION G: YOUR PRIVACY RIGHTS:

- You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment or insurance payment or eligibility for benefits.
- You may revoke this authorization at any time, but you must do so in writing and submit it to the following address: **Centric Health, Attn: Medical Records, 11612 Bolthouse Dr Suite 200 Bakersfield, CA 93311 / Medical Clinic which provided records**. Your revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- You have a right to receive a copy of this authorization.

SECTION H: Cautions before signing

- Your health information that will be released as a result of you signing this authorization could be re-disclosed by the recipient. If this occurs, your re-disclosed health information may no longer be protected by state or federal privacy law.
- We encourage you to request a copy of your records and review them before authorizing the release of the records to someone other than you.

SECTION I: Please sign and date this form to authorize Centric Health to release your information as stated on this form.

_____ _____

Patient Signature or Personal Representative **Date**

Name of legal representative signing this form; if applicable (please print): _____
Relationship to patient: _____
Phone number of legal representatives signing this form: _____
If you are not the patient and you are signing this authorization form, **PLEASE PROVIDE SUPPORTING LEGAL DOCUMENTATION** ☐

FOR OFFICE USE ONLY*

Patient/Representative Identification Verified to release: ( ) DL/ID Card ( ) Passport ( ) Other _____
Name of staff member and title of who verified:_____
Department:_____
Release Date:_____

Contact Compliance at (661)371-2771 if you have questions regarding a disclosure

A COPY OF THIS AUTHORIZATION FORM MUST BE GIVEN TO THE REQUESTOR