AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

In accordance with 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. Use or disclosure pursuant to an authorization will be consistent with the terms of such authorization.

When you complete and sign this form, health information about you will be released as you describe in the form. Please read each section carefully and complete the required sections before signing. Please clearly and legibly print all information when completing this form and sign on the last page.

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/organizations 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.

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, mental or physical condition and any treatment received by me.
- ❑ 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)

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

- ❑ Mail
- ❑ Pick up in person (Date): _____ (Location):_____
- ❑ 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.
- ❑ Check here if the release is not to the patient and provide the reason for the release here: _____

SECTION F:

EXPIRATION:

Term: 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, 5080 California Ave, Suite 420 Bakersfield, CA 93309**. 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: _____

Address of patient or legal representative signing this form (please print): _____

Phone number of patient or legal representative signing this form (please print): _____

If you are not the patient and you are signing this authorization form, describe your authority to sign on behalf of the patient and **PLEASE PROVIDE SUPPORTING LEGAL DOCUMENTATION:**

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

Patient/Representative Identification Verified:

*Staff Initials:*_____

Dept: _____

(For Office Use Only)