# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

• 32392 Coast Hwy, Ste. 250 • Laguna Beach, Ca 92651 • (949) 499-2265 Office • (949) 499-2276 Fax •

Patient Name: _____Date of Birth:_____Today's Date:_____

Address: _____SS#:_____Phone:_____

City/State/Zip: _____Email:_____

**CHECK ONE or BOTH:** *(for below)* □ Please **OBTAIN** information **FROM:** □ Please **SEND** my information **TO:**

| *Individual / Organization Name* | *Address* | *Phone* | *Fax* | *Email* | *Relationship* |
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**I hereby authorize disclosure of the following information to/from Laguna Family Health Center:**
a. □ **All health information pertaining to my medical history, mental or physical condition and treatment received;**
□ Only Financial/billing records and lists of dates/attendance of appointments at the office
□ Only the following records or types of health information or dates:_____
□ Additional Limitations, if any:_____

b. **I specifically authorize release of the following information (initial as appropriate):**
□ Psychotherapy notes:_____ □ HIV test results:_____ □ Substance use records:_____ □ Genetic test results:_____

**Purpose of requested use or disclosure:** □ Health care □ Patient request □ Legal □ Other:_____

**This authorization expires:** □ No expiration date/remains in effect unless revoked -OR- □ Expires on (date):_____

**Rights & Restrictions:** *I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or obtain a copy of this authorization to be used and/or disclosed under this authorization. Photocopy/Fax/E-signatures may be used as original. I understand I have the right to revoke this authorization in writing at any time or change what information is to be released. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization. Information disclosed pursuant to this authorization could be redisclosed by the recipient in some cases, however, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required by law.*

**Signature by or on behalf of patient:**

_____

*Name of Patient (Print)* *Signature* *Date/Time*

_____

*Name of person signing form & Relationship (if not patient)-if applicable*