HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION FOR RELEASE OF INFORMATION

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Omni Family Health

Section A: Must be completed for all authorizations

Completion of this document authorizes the disclosure and the use of health information about you. Failure to provide all information requested may invalidate this authorization.

I hereby authorize the use or disclosure of my individually identifiable health information as described below; I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Use and disclosure of health information

Patient Name: _____ Date of Birth: _____

Persons/organizations providing the information: Persons/organizations receiving the information:

_____ _____

Address, City, State, ZIP: _____ Address, City, State, ZIP: _____

Phone/Fax/E-mail:_____ Phone/Fax/E-mail: _____

Specific description of information (including dates):

1. ☐ All Health Information pertaining to my medical history, mental, or physical condition and treatment received; **OR**
2. ☐ Only the following records or types of Health Information (including Dates):

   _____

   _____
3. I specifically authorize the release of the following information (check as appropriate):
   - ☐ Mental Health treatment information
   - ☐ HIV test results
   - ☐ Alcohol/Drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

Purpose

What is the purpose of the use or disclosure:

◯ Patient Request; **OR** ◯ Other

_____

_____

_____

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Expiration

Section B: Must be completed for all Authorizations, the patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____ (DD/MM/YY) Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on my actions they took before they received the revocation. Initials: _____

My Rights

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: 4900 California Avenue, Suite 400B, Bakersfield, CA 93309

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be redisclosed by the receipt. Such redisclosure is, in some cases, not prohibited by California Law and may no longer be protect by federal confidentiality law (HIPPA). 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 requested or permitted by law.

If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.

_____ Date: _____ Time: _____ ○AM ○PM

Signature of Patient or Patient's Legal Representative
(Form must be completed before signing)

_____ _____

Printed name of Patient's Legal Representative: Relationship to patient:

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ***

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

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Omni Family Health | 4900 California Avenue, Suite 400B, Bakersfield, CA 93309
Medical Record | P: 661-459-1917 | F: 661-746-9197 | medicalrecords@omnifamilyhealth.org