

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Failure to provide *all* information requested may invalidate this authorization.

EXPLANATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq.

AUTHORIZATION

I hereby authorize:

PACIFIC ALLIANCE MEDICAL CENTER

To furnish to (name of requestor): _____

Address: _____

City / State / Zip: _____

Phone Number: _____

Pertaining to medical history, mental or physical condition, service rendered, or treatment of:

Patient Name: _____
Last
First
M.I.

Maiden or Alternate Last name Used: _____

Date of Birth: _____ Social Security: _____

The authorization is limited to the following medical records and type of information:

USES

The requestor may use the medical records and type of information authorized only for the following purposes:

DURATION

The authorization shall become effective immediately and shall remain in effect until (date): _____



RESTRICTIONS

I understand that the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPIES OF THIS AUTHORIZATION

I further understand that I have the right to receive a copy of this authorization upon my request. Copy requested and received: **YES** **NO** **Initial** _____

YOUR RIGHTS

I may refuse to sign this authorization.

I may revoke this authorization at any time, however I cannot revoke when others have depended upon this authorization.

SIGNATURE

Date: _____ Time: _____ AM/PM

Signature: _____

(Patient/representative/spouse/financial responsible party)

If signed by other than patient, indicate relationship: _____

Witness: _____

ID verified: **YES** **NO** **Initial** _____

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)

