# **AUTHORIZATION FOR RELEASE OF INFORMATION (Template)**

|  |
| --- |
| **Your Information** |
| Last Name: | First Name: | Middle Initial:  |
| Address: | City/State: | Zip Code: |

|  |  |
| --- | --- |
| **Person/Organization Providing the Information** | **Person/Organization Receiving the Information** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position or Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # : (\_\_\_\_\_) \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Fax #: (\_\_\_\_\_\_) \_\_\_\_\_\_ \_\_\_\_\_\_\_  | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Position or Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # : (\_\_\_\_\_) \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Fax #: (\_\_\_\_\_\_) \_\_\_\_\_\_ \_\_\_\_\_\_\_ |
| *45 C.F.R. §§ 164.508(c)(1)(ii), and (iii); CA Civil Code §§ 56.11(e), and (f)* |

|  |
| --- |
| **Description of the Information to be Released****(Provide a detailed description of the specific information to be released)***45 C.F.R. § 164.508(c)(1)(i); CA Civil Code §§ 56.11(d), and (g)* |
| **Check each type of confidential information you authorize to be released:**

|  |  |
| --- | --- |
|  [ ]  HIV or AIDS Information  |  [ ]  Alcohol/Drug Information  |
| [ ]  Mental Health/Behavioral Health Information  |  [ ]  Genetic Testing |

 |
| Other:  |
| For the following period of time: from\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) to\_\_\_\_\_\_\_\_\_\_\_\_\_ (date). |

|  |
| --- |
| **Description of the Purpose and Limitations for the Use or Release of the Information (Indicate how information will be used)***45 C.F.R. § 164.508(c)(1)(iv); CA Civil Code § 56.11(g)* |
|  |
| The information will not be used for any purpose other than its intended use. |

|  |
| --- |
| Will the health plan or provider receive money for the release of this information?*45 C.F.R. § 164.524(c)(4)* |
|  [ ]  Yes [ ]  No |
| Reasonable fees may be charged to cover the costs of copying and postage. |
| This authorization for release of the above information to the above named persons or organizations will expire on:       (date).*[45 C.F.R. § 164.508(c)(v); CA Civil Code § 56.11(h)]*I understand that: * I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. *[45 C.F.R. § 164.508(c)(2)(i)]*
* I have the right to revoke this authorization at any time by sending a signed notice stopping this authorization to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The authorization will cease on the date my valid revocation request is received.

*[45 C.F.R. § 164.508(c)(2)(i); CA Civil Code § 56.15]* * The Notice of Privacy Practices provides instructions for me should I choose to revoke my authorization and includes limitations on my revocation*.*

*[45 C.F.R. § 164.508(c)(2)(i)]** My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization. *[45 C.F.R. § 164.508(c)(2)(ii)]*
* Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. *[CA Civil Code § 56.13]*
* If the organization or person I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. *[45 C.F.R. § 164.508(c)(2)(iii)]*
* I have the right to receive a copy of this authorization.

*[45 C.F.R. § 164.508(c)(4); CA Civil Code § 56.11(i)]* * Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes. *[CA Civil Code § 56.104(a)(4)]*
 |
| Patient Signature: | Date: |

*[45 C.F.R. § 164.508(c)(1)(vi); CA Civil. Code § 56.11(c)]*

|  |  |  |
| --- | --- | --- |
| Patient’s (Personal) Representative Signature: | Relationship: | Date: |

*[45 C.F.R. § 164.508(c)(1)(vi); CA Civil Code § 56.11(c)]*