AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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

PART 1

Name of patient:____ Birthdate: ____/____/________

Telephone number:____________________ Email:____________________________________
Optional - Records will not be sent by unencrypted email

PART 2

I hereby authorize: ____
(Name of the Persons/Organizations authorized to release the information)

____
(Address — street, city, state, zip code)

to release the following information (*Some records may only be available on paper)*:

a) ☐ All health information pertaining to my medical history, mental or physical condition, treatment received and insurance and billing records; OR

Only the following records or types of health information (including any dates):

☐ Medical Record ☐ History & Physical ☐ Lab Test Results
☐ Office Notes ☐ Consultation Reports ☐ Billing Records

Other Medical Documents: ____

b) I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment information* ☐ Alcohol/drug treatment information
☐ HIV test results ☐ Genetic Test results

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

To: ____
(Name of the Persons/Organizations authorized to receive the information)

____
(Address — street, city, state, zip code) *(Fax#)Optional*

PART 3

Purpose of requested use or disclosure ☐ Patient request; OR ☐ Other:______________________
Date Range: From___________through______

This authorization expires on *(date)*: ____/____/____ (*if blank, expires 1 year from date signed*)

PART 4

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **Inspire Health Medical Group, Attn: Release of Information, 2625 E Divisadero Street, Fresno, CA 93721-1431.** *For help/questions filling out this form contact:* (559) 453-5200
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I understand that California law prohibits the recipients of my health information from making further disclosure of my health information unless the recipient obtains another authorization from me or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.
- If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.

Print Name: ____ Date: ____/____/____
(Patient or Legal/Personal Representative) Time: _______AM / PM
Signature: ____

If signed by someone other than patient, print name and indicate relationship:

Print name: ____ Relationship: ______________________
(Parent, Legal/Personal representative)

Print Staff Name:
____

ONLY COMPLETE THIS SECTION IF YOU ARE REVOKING THIS AUTHORIZATION
Complete PART 1 and all information below

I hereby revoke the Authorization for Use or Disclosure of my PHI

Print Name: ____ Date: ____/____/____
(Patient or Legal/Personal Representative) Time: _____ AM / PM
Signature: ____

If signed by someone other than patient, print name and indicate relationship:

Print name: ____ Relationship: ______________________
(Parent, Legal/Personal representative)

Print Staff Name:
____