

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure of individually identifiable health information that is protected by the Lanterman-Petris-Short Act for Psychiatric treatment & Alcohol Drug Abuse Regulations for Chemical Dependency treatment. **Failure to provide ALL information requested may invalidate this authorization.**

YOUR RIGHTS

- ❖ I may refuse to sign this authorization, which invalidates this authorization. ***(See notation below)**
- ❖ I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, & delivered to the John Muir Behavioral Health Center.
- ❖ My revocation will be effective upon receipt, but will not be effective to information disclosed prior to the date of revocation.
- ❖ I have a right to receive a copy of this authorization.
- ❖ The John Muir Behavioral Health Center may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization, except:
 - For research related treatment.
 - When authorization is for eligibility/enrollment/underwriting/risk rating determination.
 - When the sole purpose for creating the requested protected health information is to disclose to a third party.

I authorize the John Muir Behavioral Health Center to disclose my health information:

Psychiatrist:

Name	Phone	Fax
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*Current Provider

Address	City	State	Zip
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Therapist:

Name	Phone	Fax
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*Current Provider

Address	City	State	Zip
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PCP:

Name	Phone	Fax
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*Current Provider

Address	City	State	Zip
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Other:

Name	Phone	Fax
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*Current Provider

Address	City	State	Zip
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*Per HIPAA Continuity of Care requirements, consent is not required for current providers.

*Patient signature not required if initialed by Social Services Clinician.



**AUTHORIZATION FOR DISCLOSURE OF PROTECTED
HEALTH INFORMATION**

Other:

Name	Phone	Fax	
Address	City	State	Zip

This authorization includes information related to conditions pertaining to sexually transmitted diseases unless otherwise excluded. AIDS & HIV test result information will NOT be released unless specifically authorized.

List specific dates of treatment need for use/disclosure: _____

Exclusions: _____

List the specific records or types of health information or specific dates of treatment:

The person(s)/organization may use the information received for the following purpose only:

California law prohibits the receiver from making further disclosure of your health information unless the receiver obtains another authorization from you or unless such disclosure is required or permitted by law.

Authorization expires: _____, (if blank, authorization will expire one year from date of signature.)

Signature

Date

Print Name

Daytime Phone Number

Date of Birth

Relationship if other than patient

Witness

