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

_____ *Current Provider

Address City State Zip

Therapist:

Name Phone Fax

_____ *Current Provider

Address City State Zip

PCP:

Name Phone Fax

_____ *Current Provider

Address City State Zip

Other:

Name Phone Fax

_____ *Current Provider

Address City State Zip

*Per HIPAA Continuity of Care requirements, consent is not required for current providers.
*Patient signature not required if initialed by Social Services Clinician.

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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