TULARE COUNTY
HEALTH & HUMAN SERVICES AGENCY
Cheryl L. Duerksen, Ph.D. • Agency Director

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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

Name of Patient: _____ Date of Birth: _____

Patient contact phone #: _____ Alternate phone #: _____

RELEASE FROM:

Name/Agency: _____

Address: _____

_____

Phone: _____

RELEASE TO:

Name/Agency: Hoosier Services Inc.

Address: 18032 Lemon Dr., #C-618

Yorba Linda, CA 92886

Phone: 800.882.4156; Fax: 800.882.4957

The following information:

a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received;

OR

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

_____

b. **Initial as appropriate**, I specifically authorize release of the following information:

_____ HIV/Hepatitis/Sexually Transmitted Disease (STD) test results

_____ Alcohol/drug treatment information

PURPOSE:

Purpose of requested use or disclosure: insurance purpose

_____

EXPIRATION:

This authorization expires on (*date*): _____

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MY RIGHTS:

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the clinic providing my health services.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Signature:

Date: _____ Time: _____ AM / PM

Signature: _____
(*patient/guardian/legal representative*)

If signed by other than patient, indicate relationship: _____

Print Name: _____
(*parent/guardian/legal representative*)

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INFORMATION FOR AUTHORIZATION

The privacy and confidentiality of medical, psychiatric and substance abuse information is protected by Federal and State Statutes, Rules and Regulations (including: Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information – 45CFR Pats 160 through 164, California Confidentiality of Medical Information Act; California Administrative Code, Title 22; California Civil Code Section 56 et seq. California Welfare and Institutions Code, Section 5328; and Title 42 of the Code of Federal Regulations). These Statutes, Rules and Regulations require that the client give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations.

California Civil Code Section 56.11: An authorization to release health/hospital information will be considered valid only when it states: (1) who will release the information; (2) who will receive the information; (3) the purpose and limitations for which the information will be used; (4) what specific information will be released; and (5) when the authorization will expire. The authorization must also contain the client's/authorized representative's signature and the date of the signature. This Authorization of the Release of Protected Health Information waives any and all rights that the patient now has or may in the future have to bring any legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information or other confidential information. The authorization must be completely filled out and cannot be missing any required elements.

A minor client may only sign an authorization for the release of their health/hospital information for services, which the minor could lawfully consent. The authorization of their parent or authorized representative is needed for the release of their health/hospital information for services, which the minor could not lawfully consent. The signature of the authorized representative is required for patients who are conservatees under the Probate Code. Authorized representatives signing for the client must submit copies of the legal documents supporting the assignment of this authority.

Upon request, you will be furnished with a copy of the completed "Authorization for the Release of Protected Health Information" and "Notice of Health and/or Mental Health Information Practices."

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.