

College Health IPA
Comprehensive Behavioral Health Management

Authorization for Use or Disclosure of Personal Health Information

EXPLANATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

AUTHORIZATION

I hereby authorize (name of physician, hospital or health care provider):

To furnish to (name of request):

Medical records and information pertaining to medical history, mental or physical condition, services rendered, or treatment of (name of patient):

This authorization is limited to the following medical records and type of information:

USES

The requester may use the personal health information authorized only for the following purposes:

DURATION

This authorization shall become effective immediately and shall remain in effect until (date): _____

I understand that any requests to revise or cancel this authorization must be in writing.

Patient Name: _____

RESTRICTIONS

I understand that the requester may not further use or disclose the private health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I also understand that treatment cannot be conditioned based upon signing this authorization.

ADDITIONAL COPY

I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received _____ Yes _____ No Initial

SIGNATURE

Date: _____ Time: _____ AM / PM

Printed Name: _____

Signature: _____

If signed by other than patient, indicate relationship: _____

Witness: _____