Peach Tree Healthcare

Authorization for Disclosure of Health Information

This authorization to release medical information is being requested to you to comply with the terms of the Confidentiality of Medical Information Act, Section 56 et Esq. of the California Civil Code

Patient Name: _____ Social Security No.: _____

Date of Birth: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize the use or disclosure of the above named individual's health information as described below.

I authorize:	**Release health information to:**
Name of person/facility which has information	Name of person/facility releasing information to
Mailing Address, City, State, Zip Code	Mailing Address, City, State, Zip Code
Phone Number Fax Number	Phone Number Fax Number

This protected health information is disclosed for the following purpose: _____

I request that the designated record custodian of all covered entities under HIPAA disclose full and complete protected medical information including the following:

- ☐ Complete Health Records
- ☐ Psychiatric and/or mental health conditions*
- ☐ HIV/AIDS and/or STD results*
- ☐ Alcohol and/or drug abuse*
- ☐ Lab Results/X-Ray Results
- ☐ Immunization Record
- ☐ Physical Exam
- ☐ Other (please Specify): _____

Please **Initial** below if you want this release to include the following information; Otherwise, this information will be excluded.

* I authorize the release of my Psychiatric and/or mental health conditions. _____
* I authorize the release of my HIV/AIDS and/or STD results. _____
* I authorize the release of my Alcohol and/or drug abuse. _____

Federal and State law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside of the state of California.

I understand the following: See CFR § 164.508(c)(2)(i-iii) (a) I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization (b) The information released in response to this authorization may be re-disclosed to other parties (c) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

I hereby authorize Peach Tree Clinic (or the above named provider) to release medical information contained in their records concerning the above named patient. This authorization shall remain in effect for:
☐ 6 Months ☐ 1 Year ☐ Other: _____ *If no date is indicated, the authorization will expire 12 month after the date of my signing this form.*

I understand that I have a right to receive a copy of this authorization upon request. I also understand that this authorization may be modified or rescinded but that such rescission or modification will only be effective when delivered in writing to the Medical Records Office where this form originated. My signature authorizes the release of information indicated above. I further understand there may be a fee associated with my request for the release of information. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

Signature of Patient or Legal Representative	Relationship, If Legal Representative	Date

Print Name of Patient or Legal Representative	Witness Signature	Date