TULARE COUNTY
HEALTH & HUMAN SERVICES AGENCY
Patrick J. Hamblin • Compliance, Privacy, & Security Officer

Timothy W. Lutz, MBA
Agency Director

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED 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 Client: _____

Date of Birth: _____ MR#/Case#: _____

RELEASE FROM

Name/Entity: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

RELEASE TO

Name/Entity: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

USE AND DISCLOSURE OF INFORMATION

1. **Protected Health Information to Be Disclosed**

Select one of the following:

☐ All medical records
☐ Medical history, progress notes, physical condition and treatment received
☐ Only the following records or types of health information [including any dates]

_____

2. **I specifically authorize release of the following information (Check all that apply)**

- ☐ HIV/AIDS records
- ☐ Sexually transmitted disease records
- ☐ Communicable disease records
- ☐ Genetic testing records
- ☐ Mental health records

*Do not use this form for the release of substance use disorder records.

PURPOSE

- ☐ At the request of the patient/patient representative
- ☐ Continuation of care
- ☐ Other _____

EXPIRATION

This authorization expires on [must be specific date]: _____

MY RIGHTS

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 or to Tulare County Health and Human Services Agency Attn: Office of Compliance, 5957 S. Mooney Blvd., Visalia, CA 93277. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. 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 refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

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

SIGNATURE

Signature: _____ Date: _____

Print Name: _____

If signed by other than client, indicate relationship: _____