

# AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION



FOR OFFICE USE ONLY	PART 1: CLIENT/PATIENT INFORMATION		
CERT #	Client/Patient Last Name		Client/Patient First Name
			Middle Initial
	Other Names Used		Date of Birth
			SSN (Last 4 Digits)
MRN (If known)	Address	City	
State	Zip	Telephone Number with area code	

**PART 2: I AUTHORIZE ORANGE COUNTY HEALTH CARE AGENCY TO DISCLOSE THIS INFORMATION TO:**

Name of Person or Organization		Address	
General Designation (For 42 CFR Programs only)			
City	State	Zip	Telephone Number with area code

**PART 3: PURPOSE OF THIS AUTHORIZATION**

Patient Request   
  Continuity of Care/Medical Treatment   
  Insurance   
  Legal   
  Disability  
 Other:

**PART 4: INFORMATION THAT CAN BE RELEASED** *(Section A required, B-D if required and/or applicable)*

**A. Check only one box:**   
 Medical Record PHI   
 Summary of PHI

**B. Check appropriate boxes for type of information to be released:**

<input type="checkbox"/> Lab/Test Results	<input type="checkbox"/> WIC	<input type="checkbox"/> AMM/MSN/MSI	<input type="checkbox"/> Child Health/Immunization Records
<input type="checkbox"/> Maternal Health	<input type="checkbox"/> Pulmonary/TB	<input type="checkbox"/> X-ray Films	<input type="checkbox"/> California Children's Services (CCS)
<input type="checkbox"/> STD Treatment	<input type="checkbox"/> Dental Care	<input type="checkbox"/> X-ray Results	<input type="checkbox"/> Other:

**C. Your initials and date range of records to be released are required below for use or release of the following types of sensitive information or records:**

<input type="checkbox"/>	<b>Alcohol, Drug or Substance Abuse Records**</b>	Date From:	Date To:
<input type="checkbox"/>	<b>Mental Health</b>	Date From:	Date To:
<input type="checkbox"/>	<b>HIV/AIDS Testing and Results</b>	Date From:	Date To:

**D. Clinic(s) where treated:**

**FOR YOUR REVIEW**

I have read the contents of this form. I understand, agree, and allow the County of Orange to use and release my information as I have stated above. I also understand that signing this form is voluntary and treatment, payment or eligibility for benefits will not be affected if I do not sign this authorization. I have the right to revoke this authorization at any time in writing by sending a notice to the Custodian of Records. The revocation will not affect disclosures the Custodian has already taken action in reliance on the authorization. Information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by federal privacy law (HIPAA). Applicable State or other federal law may require recipient to obtain your written authorization before re-disclosure unless otherwise permitted by such laws. I am entitled to a copy of this form. Fees may apply to certain requests. A copy of the original authorization is valid. This authorization expires upon completion of this request.

<b>PART 5: Client/Patient Signature or Designated Legal Representative/Guardian Signature</b>		<b>PART 6: Date</b>	
X			
Legal Representative (print full name)		Legal relationship to client/patient	
Legal Representative Street Address		City	State
			Zip

**\*\* ALCOHOL AND SUBSTANCE ABUSE INFORMATION**

The information disclosed to the recipient is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit the recipient of this information from re-disclosing the information unless it is expressly permitted by the written consent of the patient or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. You have a right pursuant to §2.13(d), that upon your request you must be provided a list of entities to which your information has been disclosed pursuant to a general designation on this consent form.

**Please return completed form for processing to: HCA Custodian of Records • Fax (714) 835-9312 • 200 W. Santa Ana Blvd. Suite 180, Santa Ana, CA 92701 • Phone (714) 834-3536 • Website: <http://ochealthinfo.com/records> • COR@ochca.com**