AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

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FOR OFFICE USE ONLY	PART 1: CLIENT/PATIENT INFORMATION Client/Patient Last Name Client/Patient First Name Middle Initial								
	Other Names Used								
		Jsed							RN (If known)
	Email:			Telephone Number			with area code:		
	Address			City				State	Zip
PART 2: THE HEALTI	DISCLOSE	THIS INFO	RMATION	TO: 🗆	Chec	k if same	as above		
Name of Person or Organization Address									
General Designation (For 42 CFR Programs only)									
City		State	Zip	Telephone Numbe	er with area code	9			
PART 3: PURPOSE OF THIS AUTHORIZATION Patient Request Continuity of Care/Medical Treatment Insurance Legal Disability Other:									
PART 4: INFORMATIO			•			d. Com	plete s	tep 2 for s	specificity)
Step 1. Select one onl	y: 🔲 Me	dical Records	🗆 Summ	ary of Treat	ment				
Step 2. Select types of	f records to	be released:							
Family Health		🗆 STD) Treatment	t	🗆 Ca	alifornia	Childr	ren's Services (CCS)	
□ X-ray Results/Film	S	🗆 Pulr	nonary/TB		🗆 W	IC		🗆 Imn	nunizations
AMM/MSN/MSI		🗆 Den	tal Care		🗆 Ot	her:			
Your <i>initials and <u>date range</u> of records to be released are <u>required</u> below for use or release of the following types of sensitive information or records:</i>									
sensitive information (Di records.								
		ance Abuse R	ecords**	Date From:			Date	To:	
	g or Subst	ance Abuse R	ecords**	Date From: Date From:			Date Date	-	
Alcohol, Drug	g or Subst h		ecords**					То:	
Alcohol, Drug Mental Healt	g or Subst h sting and	Results	Records**	Date From:			Date	To:	
Alcohol, Drug Mental Healt HIV/AIDS Te	g or Subst h sting and e services v	Results were received:	Records**	Date From: Date From:	Mail		Date Date	To:)
Alcohol, Drug Mental Healt HIV/AIDS Tes Step 3. Clinic(s) where Step 4. Delivery Prefe FOR YOUR REVIEW	g or Subst h sting and e services v rence:	Results were received:	Electronic	Date From: Date From:			Date Date	To: To: □ Pickup	
Alcohol, Drug Mental Healt HIV/AIDS Test Step 3. Clinic(s) where Step 4. Delivery Prefer FOR YOUR REVIEW I have read the conter information as I have eligibility for benefits we at any time in writing B Custodian has already may be re-disclosed bo other federal law may re by such laws. I am entit is valid. This authorization	g or Subst h sting and e services v rence: nts of this stated abc vill not be a by sending taken action y the recip equire recip tled to a co tion expire	Results were received: by the form. I unders form. I unders by the form. I also under affected if I do r a notice to the on in reliance of bient and no lor bient to obtain y py of this form. s upon comple	Electronic tand, agree erstand that not sign this e Custodian n the author nger be pro our written a Fees may a tion of this r	Date From: Date From: Date From: authorization of Records rization. Info tected by fe authorization apply to certa request.	the Coun s form is y on. I have s. The revo rmation dis deral priva before re- ain request	voluntai the rigi ocation sclosed acy law disclosed ts. A co	Date Date Date ry and ht to re will no l pursua (HIPA ure unle py of th	To: To: To: Pickup treatment voke this t affect dis ant to this A). Applic ess otherw le original	d release my , payment or authorization sclosures the authorization able State or vise permitted authorization
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