AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

NOTE: ALL NUMBERED PARTS MUST BE COMPLETED FOR AUTHORIZATION TO BE VALID

PART 1: CLIENT/PATIENT INFORMATION

Client /Patient Name:

Other Names Used:

Date Of Birth: SSN (Last 4):

Address:

City: State: Zip Code:

PART 2: THE HEALTH CARE AGENCY MAY DISCLOSE THIS INFORMATION TO

☐ **SELF / SAME AS ABOVE**
(if same as above leave area blank)

Name of Person or Organization:

Address:

Telephone number with area code :

DELIVERY PREFERENCE: **(Select one only)** ☐Mail ☐Pick Up ☐Email address

PART 3: PURPOSE OF THIS AUTHORIZATION

☐Client /Patient Request ☐Continuity Of Care/Medical Treatment ☐Other:

PART 4: INFORMATION THAT CAN BE RELEASED

Select one only: ☐Medical Records ☐Summary Of Treatment (Letter)

Clinic(s)/ Facility where services were received: _____

Date From: _____ Date To: _____

☐Family Health ☐STD Treatment ☐Immunizations ☐Billing

☐X-Ray Report/Films ☐Pulmonary/TB ☐Child Health ☐CA Children Services (CCS)

☐WIC ☐Dental Care ☐Other:

Both **INITIALS** and **DATE RANGE** of records to be released are **REQUIRED** in the **YELLOW BOXES** below in order to release the following types of sensitive information records:

INITIALS **Alcohol, Drug or Substance Abuse Records**** Date From:_____ Date To:_____

****Alcohol and Substance Abuse Information: 42 CFR part 2 prohibits unauthorized disclosure of these records**

INITIALS **Mental Health** Date From:_____ Date To:_____

INITIALS **HIV/AIDS Testing and Results** Date From:_____ Date To:_____

PART 5: CLIENT/PATIENT SIGNATURE & DATE

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. Additional information on revocation of an authorization may be found in the Notice of Privacy Practices. 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.

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

If not client, Full Name and Signature of Guardian, Conservator, Or Personal Representative

*** MUST SUBMIT PROOF OF LEGAL AUTHORITY**

PLEASE RETURN COMPLETED FORM FOR PROCESSING TO: COR@ochca.com
HCA Custodian of Records 200 W. Santa Ana Blvd. Suite 180, Santa Ana, CA 92701
Phone: 714-834-3536 Website: http://ochealthinfo.com/records