AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize _____ to
(Name of patient) (Name of person or facility which has information)

release the following health information: _____

_____

To:

_____
(Name and title or facility name to receive health information)

_____ _____ _____
(Street address, city, state, ZIP code) (Telephone number) (Fax number)

For the following purposes: _____

_____

This authorization is in effect until _____ (date or event), when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Patient:	Date
Or Signed by Personal Representative: _____ On Behalf of _____ Name of Patient	Date

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE _____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFITS IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER _____

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.

NOTARIZED BY _____

ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

NOT OFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

PERSONAL REPRESENTATIVE INFORMATION

WHAT LEGAL AUTHORITY DO YOU HAVE TO MAKE MEDICAL DECISIONS FOR THE

☐ PARENT ☐ CONSERVATOR

☐ GUARDIAN ☐ EXECUTOR OF WILL

☐ MEDICAL POWER OF ATTORNEY ☐ OTHER

NOTE: ATTACHING LEGAL DOCUMENTATION IS REQUIRED TO VERIFY THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.