COUNTY OF ORANGE, CA HEALTH CARE AGENCY

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

YOU HAVE THE RIGHT TO RECEIVE A COMPLETED COPY OF THIS FORM. PHOTOCOPY/FAX COPY MAY BE USED AS ORIGINAL.

NOTE TO CLIENT: A FEE MAY APPLY TO THIS REQUEST FOR RECORDS.

CLIENT(PATIENT) INFORMATION:

1 NAME: _____

Last *First* *MI*

2 AKA: _____

3 SSN: _____ 4 BIRTHDATE: _____

I, the undersigned, hereby authorize the 5☐ Disclosure 6☐ Exchange 7☐ Request of the following Protected Health Information (PHI):

8 PHI From:

_____
8A Name of Facility Producing Records

_____
8B Street Address/Mailing Address

_____
8C City, State, Zip

9 Disclose PHI to:

_____
9A Person/Agency

_____
9B Street Address 9C Phone Number

_____
9D City, State, Zip

An authorization to disclose PHI is voluntary. Treatment, payment or eligibility for benefits will not be affected if you do not sign this authorization. Redisclosure of a person's PHI is prohibited without the specific written authorization of that person or as otherwise permitted by state or federal law. Information disclosed pursuant to this authorization may be disclosed by the recipient and no longer be protected by California or federal law.

PHI TO BE DISCLOSED: (Please initial all that apply and identify clinic and time period as necessary.)

10☐ **Summary of PHI** _____

11☐ **Mental Health PHI / Psychotherapy Notes** Clinic where treated and when:_____

12☐ **Alcohol/Substance Abuse Treatment PHI** Clinic where treated and when_____

12A☐ Urine Tests 12B☐ Progress in Treatment 12C☐ Dates of Attendance

13☐ **Medical Record PHI** Clinic where treated and when:_____

13A☐ California Children's Services 13B☐ Pulmonary/TB 13C☐ Lab/Test Results 13D☐ STD Treatment

13E☐ Child Health/Immunization Records 13F☐ Maternal Health 13G☐ Dental Care

13H☐ X-ray of _____ 3H1 ☐ Results 13H2☐ Films 13I☐ Other _____

14☐ **HIV Results/AIDS Treatment PHI** _____

15 PURPOSE OF THE DISCLOSURE OF PHI:

_____

(e.g., The request of the Individual, continuity of care, attorney access, court case, insurance, disability, etc.)

16 UNLESS OTHERWISE REVOKED IN WRITING, THIS AUTHORIZATION EXPIRES ON :

16A☐ Completion of this request (one time disclosure). 16B☐ Six Months from signature date below.

16C☐ Expires as specified:_____

You may revoke this authorization in writing at any time by sending a notice to the Custodian of Records. The authorization will stop on the date received, except if action has been taken in reliance on it.

17 TODAY'S DATE: _____ **18 SIGNATURE:** _____

19 PRINTED NAME: _____ **20 RELATIONSHIP:** _____

21 COMPLETE ADDRESS _____

Street Address City State Zip Code

22 TELEPHONE #: _____ ( ) _____

Please return the completed form for processing to the HCA Custodian of Records office, 200 W. Santa Ana Blvd, Ste 125, Santa Ana, Ca 92701
Phone (714) 834-3536: Fax (714) 835-9312