AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT

NAME: LAST	FIRST	MI	ALIASES or MAIDEN NAME

DOB	SOCIAL SECURITY No.	MEDICAL RECORD No.

ADDRESS	CITY	STATE	ZIP

HOME PHONE No.	CELL PHONE No.	WORK PHONE No.

INFORMATION

DATE RANGE ______________________

DESCRIPTION AND DETAILS

◯ Hx & PHYSICAL EXAM	◯ EMERGENCY ROOM
◯ LAB REPORT	◯ OPERATIVE REPORT
◯ X-RAY REPORT	◯ PATHOLOGY REPORT
◯ CONSULTATION REPORT	◯ DISCHARGE SUMMARY
◯ CLINIC VISITS & TREATMENTS	◯ OTHER

PURPOSE

◯ CHANGING PHYSICIANS	◯ AT PATIENT REQUEST	◯ SECOND OPINION
◯ CONTINUING CARE	◯ WORKERS' COMPENSATION	◯ LEGAL
◯ INSURANCE	◯ SCHOOL	◯ OTHER:

RECEIVING INSTITUTION

TRINITY URGENT CARE AND OCCUPATIONAL HEALTH / 10200 TRINITY PARKWAY SUITE 204 / STOCKTON, CA 95219
OFFICE: 209-233-3004 / FAX: 209-320-8757

I HEREBY AUTHORIZE ______________________________ TO USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION AS INDICATED ABOVE.

1. I understand that, unless otherwise specified, this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:
   - Substance abuse (including alcohol/drug abuse)
   - Mental health
   - Psychotherapy notes
   - HIV related information (including AIDS-related testing)

   The confidentiality of this information is required under Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in this statute.

2. I understand that this authorization will expire within ______ months from the date hereof unless otherwise specified (not to exceed 30 months). A photocopy of this form will be considered as valid as the original.

3. I understand that I may revoke this authorization at any time by notifying the healthcare facility's Privacy Officer in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

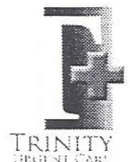
4. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

5. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

6. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

7. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.



PATIENT'S SIGNATURE or AUTHORIZED REPRESENTATIVE	DATE	RELATIONSHIP TO PATIENT