

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION
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Authorization to release the protected health information of:

Patient Name: _____ **DOB:** _____ **SSN:** _____
Current Address: _____ **City:** _____ **Zip:** _____

This Authorization is to release protected health information to:

Facility/Provider: _____ **Fax:** _____ **Tel:** _____
Address: _____ **City:** _____ **Zip:** _____

This Authorization is to release protected health information from:

Facility/Provider: _____ **Fax:** _____ **Tel:** _____
Address: _____ **City:** _____ **Zip:** _____

Purpose: **I authorize the release of my health information for the following specific purpose:**

_____.

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: **I authorize the release of the following health information: (check the applicable box below)**

- **All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.**
- **Only the following records or types of health information:**

_____.

Term: **I understand that this Authorization will remain in effect:**

- **From the date of this Authorization until the _____ day of _____, 20__.**
- **Until the Provider fulfills this request.**

- **Until the following event occurs:** _____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at PlatinumCare LA. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to PlatinumCare LA. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Signature

Date

Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

Name of Guardian/
Representative

Legal Relationship

Date

Witness