BEVERLY HOSPITAL

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

EXPLANATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide *all* information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: _____ Patient's Birth Date: _____

Persons / Organizations authorized to *use or disclose* the information: _____

Persons / Organizations authorized to *receive* the information: _____

Receiving party's address/phone/fax: _____

_____

_____

This Authorization applies to the following information (select *only one* of the following):

☐ All health information pertaining to any medical history, mental or physical condition and treatment received.
Except: _____

☐ Only the following records or types of health information (including any dates): _____

_____

I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment information

☐ HIV test results

☐ Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure: ☐ patient request; *OR* ☐ other: _____

_____

EXPIRATION

This Authorization expires on: _____

RESTRICTIONS

California law prohibits the requestor from making further disclosure of my health information unless the Requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: _____

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.

IF REQUESTOR SEEKS THIS AUTHORIZATION

My health information will be used for the following purpose(s): _____

_____

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization (see endnote for exceptions).

If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Date: _____ Time: _____ AM/PM

Signature: _____
(patient / representative / spouse / financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

Witness: _____

(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)