HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

I, ____ (patient), (____________date of birth) authorize Pacific Psych Centers, Inc. to:

_____ Release information from my medical records to the individual/organization listed below

_____ Request information from the individual/organization listed below

Name or Title of organization: ____

Address: ____________________________________ City: _______________ State: ______ Zip: __________

Phone: ___________________ Fax: ____________________ Email: __________________

☐ - All of my health information ☐ - My health information related to the following: _______________________

☐ - My health information covering the period from ___________ (date) to __________ (date)

☐ - Other: ____

This authorization ends: ☐ - On (date)___________ ☐ - One year from date signed ☐ - Other ____________

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, mental health treatment, or HIV testing and/or AIDS diagnosis or treatment**.

☐ - I consent to have the above information released. ☐ - I do not consent to have the above information released.

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed without my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

I have also had the opportunity to have this form explained to me and have my questions answered.

____ ______________

Patient/Parent/Guardian/Personal Representative Signature **Date**

____

Print Name

Jeffrey J. Hollingsworth, DO / Jessica G. Hollingsworth, MD / Rafael Ramos, PA-C
317 14th Street, Ste. A, Del Mar, CA 92014
Email: Office@PacificPsychCenters.com
PH: (858) 261-4622 FX: (858) 724-1990