



Authorization For Use and Disclosure of Health Information

Patient Name: _____ DOB: _____

Dates of Service: _____ Phone Number: _____

I authorize (name and address): _____

to release to (name and address of recipient): _____

the following health information:

- Discharge Summary, Inpatient Progress Notes, History & Physical, Operative Report, Consultation Report, Outpatient Clinic Records, Emergency Record, Laboratory Test(s), Radiology Report(s), Pathology Report(s), Immunization Records, Same Day Surgery Record, Complete Medical Record, Other: _____

Please include restricted access information relating to (initial if needed):

_____ HIV test results _____ Behavioral Health _____ Genetic Testing

The recipient may use my health information only for the following purpose(s): _____

EXPIRATION: This authorization shall become effective immediately and shall remain in effect until (enter specific date): _____

If no date is given, the authorization will be valid for one year from the date of signing.

RESTRICTIONS: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. The protection does not extend to recipients outside the state of California.

YOUR RIGHTS:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address: _____ My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid. I have a right to receive a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).

- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.
- If this box is checked _____ will receive compensation for the use or disclosure of my health information.

SIGNATURE:

Signature (Patient/Representative)

Date

Time

If signed by other than patient, print name and relationship.

When completed, check the box below for your PAMF Division and mail to the address for that facility.

PAMF Camino Division

Attention: ACTA
 701 E. El Camino Real
 Mountain View, CA 94040
 Phone: 408-523-3267
 Fax: 408-524-5034

PAMF Palo Alto Division

Attention: ACTA
 795 El Camino Real
 Palo Alto, CA 94301
 Phone: 650-853-4745
 Fax: 650-853-6093

PAMF Santa Cruz Division

Attention: ACTA
 2025 Soquel Avenue
 Santa Cruz, CA 95062
 Phone: 831-458-5520
 Fax: 831-457-0583

CLINIC USE ONLY BELOW THIS BAR

BEHAVIORAL HEALTH INFORMATION

If the health information requested pertains to behavioral health information, the undersigned physician, licensed psychologist, or social worker with a master's degree in social work who is in charge of the patient.

Approves

Disapproves

the disclosure of the health information and records described above. If disclosure is approved, any restrictions are listed below. If disclosure is disapproved, the reasons are stated below:

Date: _____

Time: _____

Signature: Physician/Psychologist/Social Worker _____

| Applicable Fees | Clerical | Copying | Delivery |
|---------------------------------------|----------|---------|----------|
| Delivered to a Health Care Provider | | | |
| Delivered to Non-Provider (3rd party) | | | |