Camellia Women's Health, KP1
5821 Jameson Ct Carmichael, CA 95608
(916) 486-0411 Fax: (916) 486-0946

Patient Information

Medical Records Release

Authorization For Use or Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning:

Patient Name: Date of Birth:

Health information to be used or disclosed (check only one box):*

__ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results.
__ Other: _____
_____
__ All psychotherapy notes may be released, except as specifically provided below:
_____

This health information may be disclosed to:

_____
(Name and address of person to use or receive the health information)

This health information may be disclosed from:

_____

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual"

_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Date: _____
Print Name: