

HIPAA/CMIA AUTHORIZATION

Patient's name: _____

Patient's Date of Birth: _____

I am either the Patient named above or the Patient's legally authorized representative.

1. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320d and 45 C.F.R. § 160–164, and/or information governed by the California Confidentiality of Medical Information Act ("CMIA") Cal. Civ. Code §§ 56–56.37. Specifically, this release authority complies with the valid authorization requirements of 45 C.F.R. § 164.508(c).
2. Pursuant to HIPAA and/or CMIA, for the purposes set forth below, I authorize and direct any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release, without restriction, all of my individually identifiable health information and medical records regarding: any past, present, or future medical or mental health condition, to include all information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness, and drug or alcohol abuse to the following designated personal representative(s) and/or to my attorney(s):

Name: _____

Name: _____

Purpose: Health Care Personal Legal Other: _____

3. California-Specific Acknowledgments

Mental Health Records:

I understand that mental health information is protected under California Welfare and Institutions Code § 5328 and requires specific authorization. This

release includes the disclosure of my mental health information as indicated in the section above.

I agree to the release of my mental health records

I do not agree to the release of my mental health records

Substance Use Disorder Treatment Records:

I understand that records regarding substance use disorder treatment are specially protected under both federal law (42 CFR Part 2) and California Health and Safety Code § 11845.5. I specifically consent to or deny the release of these records as indicated above.

I agree to the release of my substance use disorder records

I do not agree to the release of my substance use disorder records

HIV/AIDS Test Results and Information:

I understand that the release of HIV/AIDS test results or diagnosis information is subject to California Health and Safety Code § 120980. I may choose to include or exclude this information from this authorization.

I agree to the release of HIV/AIDS-related information

I do not agree to the release of HIV/AIDS-related information

Genetic Information:

I understand that the release of genetic testing results is protected under California Civil Code § 56.17. I consent or decline to include this information as indicated above.

I agree to the release of genetic testing information

I do not agree to the release of genetic testing information

4. I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, I must do so in writing. The procedure for how I may revoke this Authorization, as well as the exceptions to my right to revoke, will be performed in accordance with applicable federal law and any applicable policy of my health care provider.

5. I understand that I may refuse to sign this Authorization. I also understand that my health care provider cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility of benefits if I refuse to sign this Authorization.

6. I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by applicable federal medical privacy law and could be re-disclosed by the person or agency that receives it; however, I do not authorize such secondary disclosure.

7. The authority given to the persons and law firms named above shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. Unless otherwise revoked in writing, this Authorization for the release of PHI to the above listed individuals will expire on the date set forth below, or 18 months from the date of signature if blank.

Expiration Date: _____

I understand that I have a right to a copy of this Authorization.

Signature of Patient or Authorized

Representative:

Please print name:

Date:

