AUTHORIZATION FOR USE OR DISCLOSURE
OF
PROTECTED HEALTHCARE INFORMATION

Psychiatric Centers at San Diego
P.O. Box 609001
San Diego, CA 92160

As required by the Health Information Portability and Accountability Act (HIPAA) and California law, a medical practice may not disclose individually identifiable health information without your authorization or as provided by the Notice of Privacy Practices. Your completion of this form means that you are granting permission for us to disclose or obtain your protected healthcare information as described below. Please review and complete this form carefully. An incomplete form is invalid.

I authorize this medical practice to **obtain** or **disclose (please circle one or both)** the following information concerning *(patient name, address, and date of birth):*

____

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Healthcare information to be obtained or disclosed:

[**]** All medical records/healthcare information *EXCLUDING psychotherapy* notes. Mental health records under the Lanterman-Petris-Short Act, chemical dependency and/or alcohol treatment records. Information about my health that may relate to any disorder of the immune system including, but not limited to, HIV and AIDS results/treatment records, Communicable Diseases, EXCEPT as provided below:

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[ ] All psychotherapy notes/mental health/chemical dependency and/or alcohol treatment records. Information about my health that may relate to any disorder of the immune system including, but not limited to, HIV and AIDS results/treatment records, Communicable Diseases, EXCEPT as provided below:

____

[ ] All billing records from _________ to __________for services provided by:

____
Clinician(s) Name(s)

This information may be disclosed to or obtained from (please circle one or both):

____
Person/Entity

____
Complete Address

____
Phone Number

The information may be used only for the following purposes:

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If an *explanation is not desired write "at the request of the individual/patient"*

I understand I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect any disclosures made pursuant to this authorization before receipt of such revocation.

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

This authorization is effective now and shall remain in effect until ______________________________
Expiration date

Medical Records will be destroyed following applicable law and PCSD policy.
Re-disclosure: I understand that once my medical information has been disclosed or obtained pursuant to this authorization there is no guarantee that the recipient will not re-disclose the information to others.

Effect of refusal to sign: If this authorization is for the purpose of treatment, payment, enrollment, or eligibility for benefits, the effect of refusing to sign may affect treatment by other providers. It may also result in a health care's plan not enrolling me, may make me ineligible for benefits, may prevent me from participating in research-related treatment, or may prevent a physician from performing a medical evaluation for employment, life insurance, disability, and/or other evaluations that otherwise is done solely for disclosure to a third party.

This authorization is limited to only the information that I have requested to be used or disclosed to the persons/facilities named herein. I hereby release Psychiatric Centers at San Diego, Inc. and its employees and agents from all legal responsibilities or liability that may arise from the use or disclosure of medical/mental health records and other health information in reliance on this authorization.

Signed: ____ Date: ______________________

Print Name: ____

Witness: ____ Date: ______________________

INDICATE THE RELATIONSHIP BELOW:

[ ] Self [ ] Minor (Ages 12-17) has consented to treatment and did not need parental or guardian consent.

[ ] Parent/legal guardian of a minor

[ ] Guardian/Conservator of an incompetent patient

[ ] Beneficiary or personal representative of a deceased patient's estate

[ ] Spouse and/or other person financially responsible for payment of healthcare claims/services
(only information for purposes of processing an application for healthcare coverage or payment of healthcare services may be disclosed).