Psychiatric Centers at San Diego
P.O. Box 609001 • San Diego, California • 92160
Phone (619) 528-4600 • Fax (619) 528-4625

PCSD MRN: _____

Authorization for Use and Disclosure of Protected Health Information

This authorization allows the health care provider(s) named below to obtain or disclose confidential medical information and records. *Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, and/or alcohol/substance use/abuse have special rules that require specific authorization.*

I. Authorization: I hereby authorize Psychiatric Centers at San Diego, Feighner Research and/or TeleMedicine to obtain from or disclose my protected health information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records

To:

Name: _____
Daytime Phone #_____ Fax #_____
Address: _____
City: _____ State: _____ Zip Code: _____

II. The medical information/records will be used for the following purpose(s):

☐ Changing physicians	☐ Second Opinion
☐ Disability	☐ Legal
☐ Continuing Care	☐ Insurance
☐ At my (patient) request	☐ School
☐ Worker's Comp.	☐ Other: _____

III. This authorization is (check one):

☐ Unlimited (all records*)
☐ Limited* to the following medical information: _____

*Excluding Substance Use/Abuse, Mental Health, HIV Diagnosis/Treatment. ***Must initial below in section IV to release these specific records.***

IV. By initialing below, I also consent to the specific release of the following records:

Psychiatric/Mental Health	_____ *(Initial)*	Billing Records	_____ *(Initial)*
Therapy Progress Notes	_____ *(Initial)*	Tests for Antibodies to HIV	_____ *(Initial)*
Drug/Alcohol/Substance Use/ Abuse	_____ *(Initial)*	HIV Diagnosis/Treatment	_____ *(Initial)*
		Genetic Information	_____ *(Initial)*

V. Duration: This authorization shall be effective immediately and remain in effect until the following date: _____/_____/_____ (*Date can only be a maximum of 1 year from date signed.)*

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VI. Restrictions:

- Permissions for further use/disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required/permitted by law.
- A photocopy of this form will be considered as effective and valid as the original.
- I have been advised of my right to receive a copy of this authorization.
- The undersigned agrees that they may revoke this authorization at any time by notifying Psychiatric Centers at San Diego's Privacy Officer, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
- The undersigned agrees that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specifically protected information.
- The undersigned's health care and payment for health care will not be affected if they do not sign this form.
- The undersigned understands that their refusal to sign this authorization will not jeopardize their right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

_____ _____

Patient's Name (PRINT) **Patient's Date of Birth**

_____ _____

Patient's Social Security Number (Last 4 Digits) **Daytime Phone #**

_____

Patient's Address

_____ _____

Signature of Patient *or legal/personal representative* **Date**

_____

Legal/personal representative (PRINT)

VII. Indicate the Relationship below:

[ ] Self [ ] Parent/legal guardian of a minor [ ] Guardian/Conservator of an incompetent patient

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

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

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

VIII.

_____ _____ _____

Witness Signature **Witness Printed Name** **Date**