

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: _____
Email Address to Receive Records Electronically (Optional): _____		

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

<input type="checkbox"/> Changing physicians	<input type="checkbox"/> Second Opinion
<input type="checkbox"/> Disability	<input type="checkbox"/> Legal
<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Insurance
<input type="checkbox"/> At my (patient) request	<input type="checkbox"/> School
<input type="checkbox"/> Worker's Comp.	<input type="checkbox"/> 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.
- **Charges:** You may be responsible for payment of a reasonable, cost-based processing fee. The fee covers clerical costs as well as any/all costs associated with copying of the information.
- **Receiving Records Electronically:** If you prefer this option, provide and an email address where directed on the form. If you choose this option, you understand that there is some risk that identifiable health information and other confidential information may be misdirected, read, or intercepted by unauthorized parties.
- **Revocation:** 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)