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

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):

☐ 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 understand the release of medical records within Section IV requires specific authorization. _____ (Initials)

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse. By initialing this form, I am specifically authorizing the release of information relating to:

- Substance Abuse (include alcohol/drug)
- Psychiatric/Mental Health
- Psychotherapy Notes
- HIV Related Information
- AIDS related testing
- Genetic Information

The confidentiality of mental health records are protected under the California Welfare and Institutions Code (WIC), Title 42 of the United States code, and the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 including, but not limited to 45 CFR Parts 160 and 164; and cannot be disclosed without written consent unless otherwise provided for by the regulations. Federal and State laws require us to obtain

specific authorization from patients to release especially sensitive information. Sensitive information is defined as treatment or documentation related to Human Immunodeficiency Virus (HIV) and AIDS testing results, psychiatric care, and treatment of alcohol or drug abuse.

V. Duration: This authorization shall be effective immediately and remain in effect for 1 year from date signed unless specified below.

If you would like a sooner expiration date than 1 year, enter expiration date: _____/_____/_____

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) ***Relationship to Patient***

_____

Minor's Signature, if applicable

Minors – a minor's signature is required to release the following information including, but not limited to treatment and mental health conditions (age 12 and older), HIV/AIDS, substance abuse diagnosis.