AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of protected health information.
Failure to provide all information requested may invalidate this Authorization.

Patient's Full Name: _____ DOB: _____

I hereby authorize Pomona Pediatrics to release to:

_____
Persons/Organization authorized to *receive* the information

_____
Address (street, city, state, zip code), phone #, fax #

the following information:

- ☐ All healthcare information
- ☐ Only the following records or types of health information (including any dates): _____
- ☐ Other

_____

I specifically authorize release of the following information (check as appropriate):

- ☐ Mental health treatment information
- ☐ HIV test results
- ☐ Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure of use of psychotherapy notes.

PURPOSE

Purpose of request or disclosure: patient request OR other: _____

EXPIRATION

This authorization expires (choose date): _____
(If no date written, expires one year from date signed.)

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **Pomona Pediatrics, 250 W. Bonita Ave., Suite #200, Pomona, CA 91767**. My revocating will take effect upon receipt but does not apply to instances in which information was released from the time of authorization to the time of revocation.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law. (HIPAA)

I have a right to receive a copy of this authorization and am aware there will be a fee for administration cost to copy medical records not to exceed $25.00 payable to Pomona Pediatrics.

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____

(patient/parent/representative)

Home address: _____

Relationship to the patient:_____ Witness: _____