



# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please review and complete this form carefully. It may be determined to be invalid if not fully completed.

5. I authorize _____ to release health information to: Name of person or facility, which has the health information			
Name of person or facility to receive the health information			
Specify name/title of person to receive the health information, if known			
Street Address, City, State, Zip Code ( ) ( )			
Telephone Number	Ext	Fax Number	Email
I prefer records be sent by: <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Electronically by Secure File Transfer, if available. US Mail will be used if other methods are not available.			

**6. Expiration Date or Event of this Authorization: This authorization shall be valid - unless I revoke it earlier in writing - until: (please check one)**

- One year from the date I sign this authorization       The following date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- When the following event occurs: \_\_\_\_\_

**NOTE:** If this authorization is given by a parent or legal guardian on behalf of a minor, it will expire on the minor's eighteenth birthday.

**7. I understand that:**

- a. I may revoke this authorization at any time in writing by providing written notice to the person(s) or class of persons I am authorizing to make this use and disclosure. Yosemite Medical Clinic / Yosemite Emergency Medical Services will furnish me with a form to make my written revocation if I ask for the form but I am not required to use that form.
- b. My revocation will not apply to the information already used or disclosed at my request by this authorization.
- c. I will be able to receive any treatment or benefits I am entitled to whether or not I sign this authorization as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.
- d. When my information is used and/or disclosed as requested by this authorization, it will no longer be protected by federal health information privacy law and may be subject to re-disclosure by the recipient(s).
- e. This does not authorize use or disclosure of psychotherapy notes, sale of protected health information or uses and disclosures for marketing purposes.

**8. Signature: By signing this authorization for use and disclosure of protected health information I certify that I make this authorization voluntarily and understand that I am entitled to a copy upon request.**

<u>X</u> _____ Signature of <input type="checkbox"/> Patient or <input type="checkbox"/> Personal Representative	____/____/____ Date
_____ Printed Name of Patient or Personal Representative (if any)	_____ Personal Representative's Authority to Act for the Patient (e.g., Parent, Guardian, etc.) (Documentation may be requested)

<b>FOR OFFICE USE ONLY</b>		
Date form received ____/____/____ <input type="checkbox"/> Identity of Patient verified <input type="checkbox"/> Identity & Authority to Act of Personal Rep. verified, if applicable. Authorization determined to be <input type="checkbox"/> VALID <input type="checkbox"/> INVALID by:		
_____ Signature	_____ Printed Name/ Title	____/____/____ Date
Comments: _____		