

**AUTHORIZATION FOR USE/DISCLOSURE  
OF HEALTH INFORMATION**

**Authorization for Use/Disclosure of Information:** I voluntarily consent to an authorize my health care provider \_\_\_\_\_ (insert name) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

**Recipient:** I authorize my health care information to be released to the following recipient(s):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**Purpose:** I authorize the release of my health information for the following specific purpose: \_\_\_\_\_.  
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

**Information to be disclosed:** I authorize the release of the following health information:  
(check the applicable box below)

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.<sup>1</sup>
- Only the following records or types of health information:  
\_\_\_\_\_.

**Term:** I understand that this Authorization will remain in effect:

- From the date of this Authorization until the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.
- Until the Provider fulfills this request.
- Until the following event occurs: \_\_\_\_\_

**Redisclosure:** I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

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<sup>1</sup> NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.

