TORRANCE MEMORIAL
PHYSICIAN NETWORK

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patient's Name: _____

Date of Birth: _____ **Today's Date**:_____

DISCLOSURE OF HEALTH INFORMATION

I Hereby Authorize:

_____
(Person's Name / Doctor's Name / Organization authorized to send the information)

_____
(Address — Street and Unit Number if applicable)

_____ _____ _____
(City) *(State)* *(Zip Code)*

_____ _____
(Fax Number) *(Telephone Number)*

To Release Records To:

_____
(Person's Name/ Doctor's Name / Organization)

_____
(Address — Street and Unit Number if applicable)

_____ _____ _____
(City) *(State)* *(Zip Code)*

_____ _____
(Fax Number) *(Telephone Number)*

The Following Information:

☐ All health information pertaining to my medical history, mental or physical condition and treatment received including Mental health treatment information, HIV test results and Alcohol/drug treatment information. (A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act)

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☐ All health information pertaining to my medical history, mental or physical condition and treatment received. Excluding the information marked below (check as appropriate)

- ☐ Mental health treatment information _____(initial)
- ☐ HIV test results _____ (initial)
- ☐ Alcohol/drug treatment information _____ (initial)

☐ Only the following specific records or types of health information. Include the dates of the specific records:

_____

Any limitations to the information to be given to the person receiving verbal or written information:

_____

MY RIGHTS

Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Today's Date: _____

Print Patient's Name: _____ **Date of Birth**: _____

_____

Patient / Legal Representative's Signature

If signed by a person other than the patient, please indicate relationship:

_____

Print Name:

_____

(Legal Representative Relationship)

**Note to provider that discloses health information pursuant to an authorization must communicate any limitation contained in the authorization to the recipient [Civil Code Section 56.14]. The required notification may be accomplished by giving the recipient a copy of the authorization form.*