

PATIENT NAME: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

BIRTHDATE: _____

I authorize: _____
(Name of person and/or Facility which has information)

(Street Address, City, State, Zip Code)

to release health information to:

LINCOLN INTERNAL MEDICINE

(Specify Name/Title of Person and/or Facility to receive health information)

801 STERLING PARKWAY, STE. 120 • LINCOLN, CA 95648

(Street Address, City, State, Zip Code)

Please specify the health information you authorize to be released:

MEDICAL

MENTAL HEALTH (other than psychotherapy notes)

Type(s) of health information: _____

Date(s) of treatment: _____

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
- I specifically authorize the release of HIV/AIDS test results (Health and Safety Code §120980(g)).
- I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j)).

PATIENT NAME: _____

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The purpose of this release is for (check one or more)

- At the request of the patient/patient representative
- Other (state reason): _____

NOTICE

LIM and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity’s obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: _____

Department Name and Mailing Address

The revocation will take effect when LIM receives it, except to the extent LIM or others have already relied on it.

You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

Print Name

Signature (Patient, Parent, Guardian)

Date

Time

Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)

Witness (only if patient is unable to sign) or Interpreter