

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.)**

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

Failure to provide *all* information requested may invalidate this Authorization.

**USE AND DISCLOSURE OF HEALTH INFORMATION:**

I hereby authorize the use or disclosure of my health information as follows:

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

Patient Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Persons/Organizations authorized to use or disclose the information: (1) \_\_\_\_\_

\_\_\_\_\_

Persons/Organizations authorized to *receive* the information: \_\_\_\_\_

All providers and/or medical consultant; medical institutions; medical practices Dr. Alchemy deems necessary to conduct and manage my medical care.

Purpose of requested use or disclosure: (2) \_\_\_\_\_

To conduct and manage my medical care

This Authorization applies to the following information (select only one of the Following): (3)

All health information pertaining to any medical history, mental or physical Condition and treatment received.

[Optional] Except: \_\_\_\_\_

Only the following records or types of health information (including any dates): \_\_\_\_\_

**EXPIRATION:**

This authorization expires [insert date or event]: (4) Ten years (10) from date of signing

If no date is indicated, the authorization will expire 12 months after the date of signing this form.

**NOTICE OF RIGHTS AND OTHER INFORMATION:**

I may refuse to sign this Authorization.

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I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have the right to receive a copy of this authorization. (5)

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. (6)

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might 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.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

If this box  is checked, the Requestor will receive compensation for the use or disclosure of my information.

Date: Time: am/pm

Signature: (patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient: (7)

If this box is checked [x]: I have been offered and decline a copy of this document, but may request a copy at any request at any time.

Witness:

*(If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.)*

- (1) If the Authorization is being requested by the entity holding the information, this entity is the Requestor.
- (2) The statement “at the request of the individual” is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- (3) This form may not be used to release both psychotherapy notes and other types of health information (*see 45 CFR § 164.508(b)(3)(ii)*). If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.
- (4) If authorization is for use or disclosure of PHI for research, including the creation and maintenance of a research database or repository, the statement “end of research study,” “none” or similar language is sufficient.
- (5) Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (*see 45 CFR §164.508(d)(1),(e)(2)*).
- (6) If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows:
  - i. to conduct research-related treatment,
  - ii. to obtain information in connection with a health plan’s eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or
  - iii. to create health information to provide to a third party or for disclosure of the health information to such third party.  
Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.
- (7) The requestor is to complete this section of the form.