



## PURPOSE

Purpose of requested use or disclosure:  personal files  changing providers  moving  
OR  other: (please specify purpose below)

## EXPIRATION

This authorization will expire 30 days from the date signed unless otherwise stated.

\_\_\_\_\_ Expiration Date

## My RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. However, my refusal may hinder the release of records to the requester.

I may inspect or obtain a copy of the health information that I am begin asked to allow the use or disclosure of.

I have a right to receive a copy of this authorization.

I may revoke this authorization at any time, but I must do so in writing and submit it to the office address where this authorization was originally submitted.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

## SIGNATURE

Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

\_\_\_\_\_