STATE OF CALIFORNIA

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

All sections must be completed for the authorization to be honored. Use "N/A" if not applicable.

I. Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Phone _____ Date of Birth: _____

Street Address: _____ City/State/Zip: _____

II. Individual/Organization Authorized to Release Personal Health Records

Name: Dr. Joan Sasaki

Address: 26691 Plaza, Suite 212 City/State/Zip: Mission Viejo, CA, 92691

III. Individual/Organization to Receive the Information

Name: _____

Relationship to Patient: _____ Phone: _____ Fax: _____

Address: _____ City/State/Zip: _____

IV. Authorization Expiration Event or Expiration Date for Release of Verbal Information/ Written Correspondence

[45 C.F.R. § 164.508(c)(1)(v) & Civ. Code § 56.11(h)]

Unless otherwise revoked by the patient, this authorization for the release of health care information to the above-named individual/organization will expire on the date specified below, event identified, or 12 months from the date signed in Section IX, whichever occurs first:

Date of Expiration: _____ Event: _____

From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____

V. Health Care Records to be Released - General

[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code § 56.11(d), (g)] Recommend 2 years Maximum 10 years

I authorize records for the following period of time to be released (must be completed to receive records):

From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____

☑ Medical Services ☐ Dental Services ☐ Other: _____

NOTE: Health records released as part of this authorization may contain references related to mental health, substance use disorder, medication assisted treatment, genetic testing, communicable disease, and HIV medical conditions.

VI. Health Records to be Released - Specify

[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code § 56.11(d), (g)] Please sign in case your records contain this info

☑ Communicable Disease Records	from _____ to _____	Signature:	_____	Date: _____
☑ Genetic Testing Records	from _____ to _____	Signature:	_____	Date: _____
☑ HIV Test Results	from _____ to _____	Signature:	_____	Date: _____
☐ Medication Assisted Treatment Records	from _____ to _____	Signature:	_____	Date: _____
☐ Mental Health Treatment Records	from _____ to _____	Signature:	_____	Date: _____
☐ Substance Use Disorder Records	from _____ to _____	Signature:	_____	Date: _____

NOTE: Health records released as part of this authorization may contain references related to dental, medical, mental health, substance use disorder, medication assisted treatment, genetic testing, communicable disease, and HIV conditions.

Requests for psychotherapy notes require a separate CDCR 7385 and may not be combined with any other request for health records.

☐ Psychotherapy Notes N/A

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state laws.

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VII. Purpose for the Release or Use of the Information

[45 C.F.R. § 164.508(c)(1)(iv)]

☑ Health Care ☑ Personal Use ☐ Legal ☐ Other (please specify): _____

VIII. Authorization Information

I understand the following:

1. I authorize the use or disclosure of my individually identifiable protected health information as described above for the purpose listed. I understand this authorization is voluntary.

2. I have the right to revoke this authorization. To do so I understand I can submit my request in writing to my current institution's Health Information Management (health records). The authorization will stop further release of my protected health information on the date my valid revocation request is received by Health Information Management. [45 C.F.R. § 164.508(c)(2)(i)]

3. I am signing this authorization voluntarily and understand that my health care treatment will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii)]

4. Under California law, the recipient of the protected health information under the authorization is prohibited from re-disclosing the protected health information, except with a written authorization or as specifically required or permitted by law. [Civ. Code § 56.13]

5. If the organization or person I have authorized to receive the protected health information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.[45 C.F.R. § 164.524(a)(2)(v)]

6. I have the right to receive a copy of this authorization. [45 C.F.R. § 164.508(c)(4) & Civ. Code § 56.11(i)]

7. Reasonable fees may be charged to cover the cost of copying and postage related to releasing this protected health information. [45 C.F.R. § 164.524(c)(4) et seq. & California Health and Safety Code § 123110, et seq.]

IX. Patient Signature

[45 C.F.R. § 164.508(c)(1)(vi) & Civ. Code § 56.11(c)(1)]

Name: (Print): _____

Signature: _____ Date: _____

If no expiration date is specified in section IV, this authorization will expire 12 months from this date.

Name of person signing form, if not patient (Print): _____

Signature: _____ Date: _____

Describe authority to sign form on behalf of patient: _____

Name of translator/interpreter assisting patient, if applicable (Print): _____

Signature of translator/interpreter: _____ Date: _____

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