

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Form: Page 2 of 2

CDCR 7385 (Rev. 10/19)

Instructions: Pages 3 & 4

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

8. I understand that my substance use disorder records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be redisclosed without my written consent unless otherwise provided for by the regulations.

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: _____