California HIPAA Authorization Form

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Please complete **all sections** of this HIPAA Authorization Form. If any sections are left blank, this form will be invalid. Use N/A if not applicable.

Section 5 – Health Information to be Disclosed - General

I authorize the following Protected Health Information to be disclosed:

❑ Medical Records ❑ Dental Records ❑ Other Non-Specific

If Other Non-Specific, provide details: Eye care

Section 6 – Health Information to be Disclosed – Specific

I authorize the following Protected Health Information to be disclosed:

❑ Communicable Disease Signature: _____ Date: _____

❑ Reproductive Health Signature: _____ Date: _____

❑ Genetic Test Results Signature: _____ Date: _____

❑ HIV Test Results Signature: _____ Date: _____

❑ Mental Health Records * Signature: _____ Date: _____

❑ Substance Use Disorder Signature: _____ Date: _____

☑ Other Signature: _____ Date: _____

If "Other", provide details: Eye Care

*** Requests for psychotherapy notes require a separate HIPAA Authorization Form and may not be combined with any other request.**

❑ Psychotherapy Notes Signature: _____ Date: _____

Section 7 - Purpose of the Release or Use of Health Information

☒ Healthcare ❑ Research ❑ Marketing ❑ Sale ❑ Legal

❑ Other (please specify): _____

Note: The sale of PHI authorized by this HIPAA Authorization Form will result in remuneration to the party specified in Section 2.