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 8 - Authorization Information

I understand the following:

1. I authorize the use or disclosure of Protected Health Information as described above for the purpose indicated until such event or time as specified in Section 4.

2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party specified in Section 2. The revocation will prevent further disclosure of my health information by the party specified in Section 2 from the date of receipt. I understand a delay may exist if the party specified in Section 2 is not the covered entity authorized to disclose Protected Health Information to the party specified in Section 2. I also understand that a written revocation is not effective with respect to actions the covered entity or party specified in Section 2 took in reliance on a valid Authorization, or where the Authorization was obtained as a condition of obtaining insurance coverage.

3. I am signing this authorization voluntarily and understand my entitlement to treatment, payment, enrollment, or eligibility for health plan benefits will not be affected if I do not sign this HIPAA Authorization Form.

4. If the party specified in Section 3 is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the disclosed health information may no longer be protected by federal and state privacy regulations.

5 (if applicable). My substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization.

6 (if applicable). Information protected by the Reproductive Privacy Act (Cal. Health & Safety Code §123460-123469) may not be further disclosed by the party specified in Section 3 except in accordance with a new authorization that meets the requirements of the Confidentiality of Medical Information Act (Cal. Civil Code §56.11).

7. I have a right to receive a copy of this HIPAA Authorization Form and may request a digital version of this signed authorization.