# 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. (Page 4 of 4)

| **Section 9 - Additional Conditions or Limitations of Use that Apply to this HIPAA Authorization Form** |
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| **Section 10 - Signature by or on Behalf of Patient/Plan Member** |
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| Name of Patient/Plan Member (Print):_____ |
| Signature: _____ Date: _____ |
| Name of signatory if not patient/plan member: _____ |
| Authority to sign on behalf of patient/plan member: _____ |
| Name of translator (if applicable): _____ |
| Signature of translator (if applicable)_____ |