Authorization for Use or Disclosure of Heath Information

Completion of this form authorizes the disclosure and use of Protected Health Information (PHI) about you. Failure to provide all information requested may invalidate this authorization.

Patient name:____

DOB:____________________

Use and Disclosure of Protected Health Information

I hereby authorize the two-way release of information between The Solstice Clinic and:

____
Persons/Organizations authorized to give/receive your health information

____
Address (street, city, state and zip code)

____________________________ ____________________________
Phone number fax number

____
Email address

The following information: (check as appropriate):

a. □ All health information pertaining to my medical history, mental or physical condition and treatment received; OR

b. □ Only the following records or types of information (including any dates):

____

____

____

c. I specifically authorize the release of the following information (check as appropriate):

□ Mental health treatment information _______________________________(initial)

□ HIV test results _________________________________ (initial)

□ Alcohol/drug treatment information _______________________________(initial)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act (HIPAA).

Purpose

Purpose of requested use or disclosure: □ Patient request; OR □ Other:

____

____

____

Limitations, if any: ____

____

____

Expiration

This authorization expires on (date): ____

My Rights

*I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment.

*I may inspect or obtain a copy of the health information that I am being asked to allow the disclosure of.

*I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

The Solstice Clinic, 10921 Wilshire Blvd. Suite #412 Los Angeles, CA 90024

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

*I have the right to receive a copy of this authorization

*Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected under the HIPAA law. However, California law prohibits the person receiving any health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such discloser is specifically required or permitted by law.

Signature

Date:______________________________________

Signature:____

Patient/legal representative

If signed by a person other than the patient, indicate relationship: ____________________

Print name:____