KVHD "We Care For You" Kern Valley Healthcare District
6412 Laurel Ave - Mt. Mesa - P.O. Box 1628, Lake Isabella, CA 93240 - (760) 379-2681 Fax (760) 379-0066

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and the use of health information regarding your care. Failure to provide all information requested may invalidate this authorization.

PATIENT INFORMATION

PATIENT NAME:	MAILING ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP CODE:
SSN:	TELEPHONE NUMBER:

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize **Kern Valley Healthcare District** to ***release information to***:	I hereby authorize _____ ***to obtain information from:***
_____ Provider Name/Organization/Person or specify SELF if applicable	_____ Provider Name/Organization/Person or specify SELF if applicable
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Phone Number	_____ Phone Number

Information to be released:

☐ All health information pertaining to my medical history, mental or physical condition and treatment received;

OR

☐ Only the following records or types of health information (including any dates):

_____

I specifically authorize release of the following information: (INITIAL)

	Mental health treatment information		HIV test results		Alcohol/drug treatment information

*A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of request for information:

☐ Patient request/personal ☐ Healthcare ☐ Insurance Coverage

☐ Other: _____

EXPIRATION

This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified below:

_____**OR**_____

END DATE EVENT NAME

MY RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use of disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: *Kern Valley Healthcare District*
  6412 Laurel Ave./P.O. Box 1628
  Lake Isabella, CA 93240
  My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a 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 by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

☐ If this box is checked, the Requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Date:	*Time:*

Signature: _____
(PATIENT/LEGAL REPRESENTATIVE)

If signed by a person other that the patient, indicate relationship: _____

Print Name: _____
(LEGAL REPRESENTATIVE)

INTERNAL USE ONLY:

COMPLETED BY:	***DATE RECORDS MAILED/PICKED UP:***	***FEE (IF APPLICABLE)***

ADDITIONAL NOTES: