L L P M G
Loma Linda Psychiatric Medical Group

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Authorization For Use And/Or Disclosure of Protected Health Information

Completion of this document authorizes the use and/or disclosure of your health information. Please read the entire document thoroughly before signing. ***Failure to provide all information requested may invalidate this authorization.***

Patient Name: _____Date of Birth: _____/_____/_____

I authorize the following person(s) and/or organization(s) to **DISCLOSE** my protected health information (as specified below):

Name(s) / Organization(s):
Address:
Email:
Phone:
Fax:

I authorize the following person(s) and/or organization(s) to **RECEIVE** my protected health information, as disclosed by the person(s) and/or organization(s) above.

Name(s) / Organization(s):
Address:
Email:
Phone:
Fax:

Information to be Disclosed (check all that apply)

- ☐ Psychiatric mental health records
  (Treatment dates: ____/____/_____ to ____/____/_____)
- ☐ Psychological/neuropsychological testing results
- ☐ Billing records
- ☐ Treatment summary/ discharge summary
- ☐ Other (specify): _____

Note: Psychotherapy notes (as defined by HIPPA) are NOT included in this authorization unless specifically checked here:

- ☐ Psychotherapy notes

Patient Rights

I understand that I may refuse to sign this Authorization, and my refusal will not affect my/my child's health plan enrollment, benefit eligibility, or ability to obtain treatment, except as permitted by law.

I have a right to receive a copy of this Authorization. I may revoke this Authorization in writing at any time, signed by me or on my behalf, except to the extent that others, including LLPMG, have acted in reliance upon this Authorization. Revocation will be effective when it has been received by LLPMG at the following address: 1007 E. Cooley Dr. Ste. 109 Colton, Ca 92324, or by Fax: (888) 505-0620.

This Authorization becomes effective upon signing and will expire on ____ /____/_____ . If no expiration date is indicated, this Authorization will automatically expire 180 days from the signature date.

Information disclosed pursuant to this Authorization could be redisclosed by the recipient. California law prohibits recipients of your/your child's health information from redisclosing such information except with your written authorization or as specifically required or permitted by law. However, in some cases, redisclosure is not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA).

Form of Release

I would like the health information provided to the Recipient in the following format:

- ☐ Fax
- ☐ Email

Signature

_____	_____
Printed Name of Patient/ Personal Representative	Relationship to Patient
_____	_____/_____/_____
Signature of Patient/ Personal Representative	Date

*****_If the person signing the form is other than the patient or parent, please attach documentation of authority._