

LOMA LINDA PSYCHIATRIC MEDICAL GROUP

1007 E. Cooley Dr., Ste. 109, Colton, CA 92324 • (909) 370-4700

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

("Consent to Release Information")

Completing this form authorizes the use and/or disclosure of health information as described below. Please read the entire form before signing. **A separate authorization is required to release psychotherapy notes.**

Patient Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

1. I Hereby Authorize the Release of Information From:

Name of Provider/Organization: _____

Address: _____

City, State, ZIP: _____ Phone: _____ Fax: _____

2. To Release Information To:

Name of Individual/Provider/Organization: _____

Address: _____

City, State, ZIP: _____ Phone: _____ Fax: _____

3. Information to Be Released

Select one:

☐ All health information regarding my medical history, mental or physical condition, and treatment received.

☐ Only the following records or types of information (include dates, if applicable):

The following categories require your specific initial before they may be released, even if you selected "all health information" above:

☐ Mental health treatment records Initial: _____

☐ Psychological testing results Initial: _____

☐ Alcohol or drug treatment records Initial: _____

4. Purpose of Disclosure

- ☐ Continuity of care / treatment coordination ☐ Personal use ☐ Legal proceeding
- ☐ Other: _____

5. Expiration

This authorization expires one year from the date signed below, unless a different expiration date or event is specified here: _____

6. Your Rights

1. You do not have to sign this authorization. Your refusal will not affect your ability to obtain treatment, payment, or eligibility for benefits from this Practice.
2. You may revoke this authorization at any time by submitting a written request to the provider/organization named in Section 1. Revocation will take effect upon receipt, except to the extent the Practice has already acted in reliance on this authorization.
3. You have the right to receive a copy of this signed authorization.
4. Information disclosed under this authorization may be redisclosed by the recipient and, once redisclosed, may no longer be protected by federal privacy law (HIPAA). However, California law generally prohibits the recipient from redisclosing your information without a new authorization from you, unless redisclosure is otherwise specifically required or permitted by law.

7. Signature

I have read this authorization (or had it read to me), understand it, and agree to the use and disclosure of health information as described above.

Patient Signature / Date

Printed Name

Legal Representative Signature / Date (if applicable)

Printed Name / Relationship to Patient

Witness / Staff Signature / Date

Copy Provided to Patient? ☐ Yes ☐ No