FORM 16-1

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide *all* information requested may invalidate this Authorization.

HASMUKH AMIN, M.D. - USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize _____ to release to:

_____

Persons/Organizations authorized to *receive* the information — Address (street, city, state, zip code)

the following information:

A. ❑ 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):

_____

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

❑ 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 requested use or disclosure: ❑ patient request; ***OR*** ❑ other: _____

_____

EXPIRATION

This Authorization expires [insert date or event]:[1] _____

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.[2]

[1] If authorization is for use or disclosure of PHI for research, including the creation and maintenance of a research database or repository, the statement "end of research study," "none" or similar language is sufficient.

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

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: 9508 Stockdale Hwy., #150, Bakersfield, CA 93311. 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.[3]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.[4]

SIGNATURE

Date: _____ Time:_____ am/pm

Signature:_____
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient: _____

Witness: _____

---

[2] If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[3] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see 45 C.F.R. Section 164.508(d)(1), (e)(2))*.

[4] The requestor is to complete this section of the form.