A. **EXPLANATION:** THIS AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION IS BEING REQUESTED OF YOU TO COMPLY WITH THE TERMS OF ONE OR MORE OF THE FOLLOWING:

INITIALS:

GENERAL MEDICAL RECORD INFORMATION:

________ CONFIDENTIALITY OF MEDICAL INFORMATION ACT OF 1981, CALIFORNIA CIVIL CODE SECTION 56 ET SEQ.

ALCOHOL, AND/OR DRUG ABUSE INFORMATION:

________ FEDERAL REGULATIONS, CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS, 42 C.F.R. SECTION 2.31.

PSYCHIATRIC INFORMATION:

________ LANTERMAN-PETRIS-SHORT ACT, CALIFORNIA WELFARE AND INSTITUTIONS CODE, SECTION 5328.7.

RESULTS OF THE HIV ANTIBODY BLOOD TEST:

________ HEALTH AND SAFETY CODE, SECTION 120980 (g)..

B. AUTHORIZATION: I HEREBY AUTHORIZE ________________________ TO FURNISH TO
(NAME OF PHYSICIAN, HOSPITAL OR HEALTHCARE PROVIDER, OR OTHER)

________________________ ________________________
(NAME OF REQUESTOR) (TELEPHONE NUMBER)

____
(ADDRESS, CITY, STATE, ZIP CODE)

MEDICAL RECORDS AND INFORMATION PERTAINING TO MEDICAL HISTORY, MENTAL OR PHYSICAL CONDITION, SERVICES RENDERED, OR TREATMENT OF (NAME OF PATIENT) ________________________. THIS AUTHORIZATION IS LIMITED TO THE FOLLOWING MEDICAL RECORDS AND TYPE OF INFORMATION: ________________________

C. **USES:** THE REQUESTOR MAY USE THE MEDICAL RECORDS AND TYPE OF INFORMATION AUTHORIZED ONLY FOR THE FOLLOWING PURPOSES: ________________________

D. **DURATION:** THIS AUTHORIZATION SHALL BECOME EFFECTIVE IMMEDIATELY AND SHALL REMAIN IN EFFECT UNTIL ________________ OR ONE YEAR FROM SIGNATURE DATE WHICHEVER IS SOONER.

E. **RESTRICTIONS:** I UNDERSTAND THAT REQUESTOR MAY NOT FURTHER USE OR DISCLOSE THE MEDICAL INFORMATION UNLESS ANOTHER AUTHORIZATION IS OBTAINED FROM ME OR UNLESS SUCH USE OR DISCLOSURE IS SPECIFICALLY REQUIRED OR PERMITTED BY LAW.

F. **ADDITIONAL COPY:** I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON MY REQUEST. COPY REQUESTED AND RECEIVED: ☐ YES ☐ NO INITIALS ________

G. ________________________
SIGNATURE (PATIENT/REPRESENTATIVE/SPOUSE*/FINANCIALLY RESPONSIBLE PARTY*) RELATIONSHIP TO PATIENT WITNESS

DATE: ____________ TIME: ____________ A.M./P.M.

*A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependant for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.

OFFICE USE ONLY

STATEMENTS
☐ WORK ☐ INSURANCE ☐ IMMIGRATION
☐ SCHOOL ☐ DISABILITY ☐ HAND CARRY
☐ OTHER

VERIFICATIONS
☐ PREGNANCY ☐ DEATH
☐ BIRTH ☐ TREATMENT

REPORTS
☐ X-RAYS
☐ PATHOLOGY SLIDES
☐ AUTOPSY

DIAGNOSIS: ________________________

OTHER: ________________________

SPECIFIC SERVICE DATES: ________________________

PATIENT'S PHONE NUMBER: ________________________

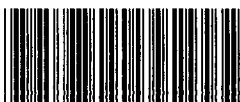
SOCIAL SECURITY NUMBER: ________________________

PATIENT'S DATE OF BIRTH: ________________________

MOTHER'S MAIDEN NAME: ________________________

SEX: ☐ MALE ☐ FEMALE

IMPRINT I.D. CARD (NAME MRUN CLINIC/WARD)



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