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How to Complete Your HIPAA Authorization

Authorization to Release Health Information (HIPAA and California Civil Code Section 56.11)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR HIPAA AUTHORIZATION.

About this form. A HIPAA authorization lets your doctors, hospitals, health plans, and pharmacies share your health information with the people you choose — a spouse, adult child, caregiver, or your agent — so they can help manage your care and bills. It does **not** let anyone make medical decisions for you; for that, use a California Advance Health Care Directive. This form is printed in 14-point type as California law requires.

1. **Identify yourself (Section 1)**
   Your full name, date of birth, and address let providers match the authorization to your records.
2. **Name who may release your information (Section 2)**
   List your main doctors, hospital, health plan, or pharmacy. Mark the box to include any other provider that has treated you.
3. **Name who may receive it (Section 3)**
   Up to three people or organizations. Many families list a spouse, adult children, and their health care agent.
4. **Choose the information and purpose (Sections 4–5)**
   Release everything, or only what you list. Mental health, HIV, substance use, and genetic information are released only if you mark the box **and** initial it.
5. **Set the expiration (Section 6)**
   California limits an authorization to one year unless you write in a specific later date. Renew it each year if needed.
6. **Sign and date it (Section 8)**
   Many clients sign this at the same notary appointment as their Advance Health Care Directive or power of attorney. A notarized signature gives providers confidence the signature is genuine. Bring a current photo ID.

After It's Signed

- Give a copy to each provider or plan named in Section 2, and to each person in Section 3. Keep a copy for yourself.
- Some hospitals and health plans also ask you to sign their own form. If so, you can bring this one along for reference.
- To cancel it, send a written revocation to each provider. Sign a new authorization when this one expires.

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California-Commissioned Notaries

SCAN TO BOOK

Questions about this document? Talk to an attorney. Gavrilov & Brooks Law Firm has attorneys licensed in California, Nevada, and other states. Phone and video consultations are available. **(916) 504-0529** · **www.gavrilovlaw.com**

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YOUR FORM BEGINS ON THE NEXT PAGE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(HIPAA, 45 C.F.R. § 164.508; California Civil Code § 56.11)

1. PATIENT

_____ _____

(full name of patient) (date of birth)

_____ _____ _____

(street address) (city) (state / ZIP)

_____

(phone)

2. WHO MAY RELEASE MY INFORMATION

I authorize the following health care provider(s), health plan(s), and pharmacy(ies) to release my information:

_____

(name of provider, plan, or pharmacy)

_____

(name of provider, plan, or pharmacy)

_____

(name of provider, plan, or pharmacy)

☐ **And** any other doctor, hospital, clinic, health plan, pharmacy, or other health care provider that has treated me or paid for my care.

3. WHO MAY RECEIVE MY INFORMATION

My information may be released to the following person(s) or organization(s):

_____ _____

(full name of person or organization) (relationship)

_____ _____

(phone) (email or address)

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(full name of person or organization) (relationship)

(phone) (email or address)

(full name of person or organization) (relationship)

(phone) (email or address)

4. INFORMATION TO BE RELEASED (mark one)

☐ My complete health records, including diagnoses, test results, treatment, medications, and billing and payment records.

☐ Only the following information:

(limit to dates of service from, if any) (to)

Specially protected information. The following is released **only** if I mark the box and initial the line:

☐ Mental health treatment information Initials: _____

☐ HIV / AIDS test results Initials: _____

☐ Alcohol or drug (substance use) treatment Initials: _____

☐ Genetic testing information Initials: _____

*This authorization does **not** include psychotherapy notes, which require a separate authorization.*

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5. PURPOSE AND USE (mark all that apply)

- ☐ At my request, so the person(s) in Section 3 can help with and make arrangements for my care.
- ☐ Billing, insurance, and payment matters.
- ☐ Legal matters.
- ☐ Other:

_____

(describe)

The person(s) receiving my information may use it only for the purpose(s) marked above, and may not use or share it for any other purpose except as I state here or as permitted by law:

6. EXPIRATION (mark one)

- ☐ This authorization expires one year from the date I sign it.
- ☐ This authorization expires on the following date (if more than one year from signing, I specifically request this date):

_____

(expiration date)

- ☐ This authorization expires upon the following event, or one year from the date I sign it, whichever comes first:

_____

(event)

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7. MY RIGHTS

I understand that:

(a) I may revoke this authorization at any time by sending a written revocation to each provider or plan named in Section 2. Revocation does not apply to information already released in reliance on this authorization.

(b) My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on whether I sign this authorization, except as permitted by law.

(c) Information released under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy law. California law prohibits the recipient from further disclosing my medical information unless another authorization is obtained or the disclosure is specifically required or permitted by law.

(d) I have the right to receive a copy of this authorization.

8. SIGNATURE

X _____ _____

(signature) (date)

_____

(printed name of person signing)

If signed by someone other than the patient, describe the legal authority to act for the patient (for example: health care agent, conservator, parent of a minor, personal representative of a deceased patient):

_____

(relationship / legal authority)

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CERTIFICATE OF ACKNOWLEDGMENT

Notary acknowledgment of the signature on this HIPAA Authorization.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)

County of _____)

On _____ before me, _____

(here insert name and title of the officer)

personally appeared _____

, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

(Seal)

Signature _____