Father Joe's Villages
Village Health Center

Authorization for Use or Disclosure of Protected Health Information

Client Name:_____
Last First M.I.

Date of Birth: _____ Records requested by: _____ MD. Patient Staff
Month/Day/Year

Coordination of Care Only? ☐ Yes ☐ No Faxed Records Needed? ☐ Yes ☐ No

This document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

I hereby authorize:

NAME OF DISCLOSING PARTY: _____

ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

To use or disclose the following health care information:

- ☐ _____ (initial): Medical injuries, illnesses and conditions
- ☐ _____ (initial): Mental health treatment information
- ☐ _____ (initial): HIV test results and/or Alcohol/drug treatment information
- ☐ _____ (initial): Psychotherapy notes
- ☐ _____ (initial): Alcohol – Other drug treatment information
- ☐ _____ (initial): Other: _____

Dates of Services provided: _____

You may disclose this health care information to:

_____
NAME OF RECEIVING PARTY

_____
ADDRESS CITY STATE ZIP CODE

_____
PHONE NUMBER FAX NUMBER

Father Joe's Villages
Village Health Center

Reason(s) for this Authorization (Initial all that apply):

___ For informing care and treatment ___ For obtaining Social Security disability benefits

This Authorization expires one (1) year from the date signed unless otherwise stipulated.

I understand that the information may/will include treatment for mental and/or physical illness, counseling or treatment for drug/alcohol abuse, human immunodeficiency virus (HIV), including acquired immunodeficiency syndrome (AIDS) or tests for HIV or AIDS.

My Rights

- I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization.
- California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect and copy any information used or disclosed under this Authorization. I understand that a fee may be charged for such copying services.
- I have a right to receive a copy of this Authorization.

Signature

I hereby release Father Joe's Villages, its employees, officers, and health professionals from any legal responsibility or liability for disclosure of the above information to the extent authorized herein. However, the confidentiality of information concerning treatment of alcohol or drug abuse is protected by federal law. Further disclosure is prohibited without written consent.

A photocopy of this Authorization will serve as the original.

_____

Signature of Client/Patient/Representative Date

Patient Name (Printed): _____

Relationship to Client/Patient:_____

_____

Witness: Date: