STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF HEALTH CARE SERVICES
PRIVACY OFFICE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ______________________________, hereby authorize a general release of my medical
(Name of Patient)
records to any and all of my medical providers. My general medical records may include information of diagnosis and/or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This may include information and treatment of mental illness and the use of alcohol and tobacco, but excludes psychotherapy notes.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Patient:____	Date: __________
Or Signed by Personal Representative: ______________________ On Behalf of: ____ (Name of Patient)	Date: __________