Bakersfield Family Medical Center
4570 California Avenue, Bakersfield, CA 93309
661-327-4411

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize _____
(Name and address of physician or health care provider authorized to use or disclose information)

To furnish to _____
(Name and address of person/organization to which disclosure is made)

Health information described below on: _____
(*Patient name)*

For the purpose of: _____

This information is limited to the following type and amount of information. (Use dates where appropriate).

- ☐ Progress Notes
- ☐ Consultation Reports
- ☐ Laboratory, Pathology Reports
- ☐ Radiology Reports/Imaging Reports
- ☐ Immunization Records
- ☐ Any and all records for the last 2 years
- ☐ Medical Records relating to injury
- ☐ Other: _____

DISCLOSURES REQUIRING SPECIAL CONSENT:
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis or treatment for: (*initial appropriate area*)

HIV/AIDS virus_____ Mental Health/Psychiatric Disorders_____
Sexually Transmitted Diseases_____ Drug, Alcohol Abuse/Treatment_____

I understand that I have a right to revoke this authorization at any time. I understand that my revocation must be in writing and presented to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Treatment, payment, enrollment and/or eligibility for benefits will not be conditioned on me providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management. I understand I have a right to receive a copy of this authorization.

Signature of Patient, Parent or Legal Guardian	Patient Date of Birth
If signed by other than patient, indicate relationship	Patient Address
Patient telephone number	
Witness signature	Date

PLEASE RETAIN A COPY OF YOUR SIGNED AUTHORIZATION.