Authorization to Release Protected Health Information

Completion of this form authorizes the release of protected health information, as described below, consistent with California and Federal Law and Regulations. **I have a right to receive a copy of this authorization.**

PATIENT'S LAST NAME | FIRST NAME | MIDDLE NAME | BIRTH DATE

STREET | CITY | ZIP CODE | TELEPHONE

I, the undersigned, hereby authorize the Imperial County Public Health Department to release health information to:

PROVIDER/ORGANIZATION/PERSON

ATTENTION | TELEPHONE | FAX

STREET ADDRESS

CITY | STATE | ZIP CODE

I understand that the provider, organization or person designated on this form to receive my health information may not further use or disclose my protected health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Health information to be disclosed:

Use and limitation of the health information disclosed:

Expiration: Unless otherwise revoked, this authorization will expire on the following date

If I do not specify an expiration date, this authorization will expire in one (1) calendar year from the date it was signed.

Revocation: I may revoke this authorization in writing at any time by sending a notice to the Imperial County Public Health Department. My revocation will be effective upon receipt, but will not be effective to the extent that the information may have already been released on the basis of this authorization.

SIGNATURE: | **RELATIONSHIP** | **DATE**

Relationship must be one of the following Patient/Parent/Legal Guardian/Personal Representative