



# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

## CLIENT IDENTIFICATION

|                        |                            |               |
|------------------------|----------------------------|---------------|
| NAME (Last, First, MI) | DATE OF BIRTH (mm/dd/yyyy) | RECORD NUMBER |
|------------------------|----------------------------|---------------|

Complete all sections, date, and sign

## I. AUTHORIZATION

I, \_\_\_\_\_ (name of client) voluntarily authorize the disclosure of information from my health record.

|   |                                       |
|---|---------------------------------------|
| <b>II. THE INFORMATION IS TO BE DISCLOSED BY:</b> | <b>III. AND IS TO BE PROVIDED TO:</b> |
|---|---------------------------------------|

|                                      |     |                                      |     |
|--------------------------------------|-----|--------------------------------------|-----|
| NAME OF PERSON/ORGANIZATION/FACILITY |     | NAME OF PERSON/ORGANIZATION/FACILITY |     |
| ADDRESS, CITY/STATE                  |     | ADDRESS, CITY/STATE                  |     |
| PHONE                                | FAX | PHONE                                | FAX |

If this box is checked, you consent to information being exchanged between the organizations/people/facilities identified in II and III above.

## IV. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

Treatment, Payment or Other Healthcare Operations  
 Attorney  
 School  
 Other (Specify) \_\_\_\_\_  
 Personal Use  
 Disability  
 Research

## V. THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD: (check appropriate box(es))

Only information related to (specify) \_\_\_\_\_  
 Only the period of events from \_\_\_\_\_ to \_\_\_\_\_  
 to Other (specify) (Billing, etc.) \_\_\_\_\_  
 Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

Substance Use Disorder Treatment/Referral  
 HIV/AIDS-related Treatment  
 Mental Health (Other than Psychotherapy Notes)  
 Sexually Transmitted Diseases  
 Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

## VI. AUTHORIZATION

I understand that I may revoke this authorization in writing submitted at any time to the Momentum for Health Quality Improvement Department, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

\_\_\_\_\_  
(Specify new date (mm/dd/yyyy) or expiration event)

### CHECK THIS BOX IF ROI HAS BEEN REVOKED

I understand that my treatment or eligibility for care is not contingent on my providing this authorization.

I understand that the recipient of my information is prohibited from re-disclosing it without written authorization or as specifically permitted by California Civil Code section 56.10. However, if the recipient is not a HIPAA Cover Entity or Business Associate as defined in 45 CFR section 160.103, the released information may no longer be protected by federal regulations.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act, Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

**SPECIFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS:** I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Insurance Exchange.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

\_\_\_\_\_  
DATE (mm/dd/yyyy)

IF NOT PATIENT – state name & relationship to patient: \_\_\_\_\_  
This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

**Instructions for Completing This Form**  
**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

1. If completing by hand, print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of client whose information is to be released.
3. Section II, print the name and address of the facility releasing the information. Section III, provide the name of the person, facility, and address that will receive the information.
4. Section IV, state the reason why the information is needed, e.g., continuing medical care, legal, research-related projects, etc.
5. Section V, check the appropriate box as applicable.
  - a. **Only information related to** – specify diagnosis, condition, special therapies, etc.
  - b. **Only the period of events from** – specify date range, e.g., Jan. 1, 2025, to Feb. 1, 2025.
  - c. **Other (specify)** – e.g., Billing.
  - d. **Entire Record** – complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).
  - e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES *MUST* BE CHECKED BY THE PATIENT.**
  - f. **Psychotherapy Notes ONLY – IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES (which are separate from progress notes and contain the therapist’s impressions and the content of psychotherapy conversations), ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**  
**IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.**
6. Section VI, if a different expiration date or event is desired, please specify.
7. Section VI, Please sign (or mark) and date.
8. A copy of the completed form will be given to you.
9. Although Momentum has taken steps to secure electronic communications, there are still risks involved in the electronic transmission of PHI. Please see Texting and Email Risks and FAQs for further information. Please contact the Momentum Quality Improvement Department to opt out of electronic communications.