Completion of 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. **Failure to provide all information requested may invalidate this authorization. Please print and use black or blue ink.**

Patient's Name _____ Medical Record # _____
(Last Name) (First Name) (Middle Initial)

Date of Birth _____ Social Security No. _____ Phone No. _____

Authorization

I hereby authorize **Emanate Health** to furnish to
(Name of Facility)

_____
(Name) (Address)

_____
(City) (State) (Zip Code) (Area Code) (Phone Number)

the following information:

- ☐ Complete Chart
- ☐ Resume
- ☐ Mental Health
- ☐ Other _____
- ☐ X-ray and Imaging Reports
- ☐ Lab Results
- ☐ Employee Health
- ☐ HIV Records
- ☐ ER ONLY Lab and/or Rad Reports
- ☐ ST Video Recording ($10 fee)
- ☐ Clinic Records

Uses

This information for which I'm authorizing disclosure will be used for the following purpose:

_____

Patient's Rights

- I may refuse to sign this Authorization.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the Health Information Management Department.
- 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.
- I have a right to receive a copy of this authorization.

Duration of Authorization

This authorization will expire on the following date, event or condition _____ If I fail to specify an expiration date or event, this authorization will expire 6 months from the date on which it was signed.

Restrictions

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, 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.

X _____
Signature of patient or legal representative Date/Time Relationship to patient (if signed by Legal Representative)

_____
Witness Date/Time

EmanateHealth™

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION