GENERAL AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

EXPLANATION: This Authorization is necessary for us to comply with state and federal laws pertaining to the use and disclosure of protected health information (PHI) about the patient identified below. Please provide all requested information.

Name of Patient_____Date of Birth_____

1. **PERSONS AUTHORIZED TO DISCLOSE PHI**: I authorize the following person(s) or class of persons to disclose the health information about patient as described in Section 2 below:(state name of physician or specific identification of person or class of person(s):

_____

_____

2. **DESCRIPTION INFORMATION**: This Authorization permits the use and/or disclosure of the following information about patient: (Check all that apply and initial selection as required)

☐ _____(Initial) All my health information pertaining to any medical history, physical condition and treatment received.

☐ _____(Initial) Itemized Billing Statement

OR

☐ _____(Initial) Only the following records or types of health information and/or only specified date(s):

Date(s) of treatment_____

Type of treatment_____

☐ _____(Initial) Records for the treatment of drug and/or alcohol abuse.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3.AUTHORIZED USERS AND RECIPIENTS: I hereby authorize the following person or class of persons to receive and/or use the health information described in section 2 above:_____

_____

and their authorized representative: Expedite Document Imaging, 614 Scenic Drive, Suite 203, Modesto, Ca 95350,
209-575-2901

4. PURPOSE. I hereby authorize the information checked in Section 2 above to be used and/or disclosed for the following purpose:

[X] Requested by patient or personal representative

5. RIGHT OF REVOCATION. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the provider.

6. LIMITS TO REVOCATION. I understand that my revocation will be effective upon its receipt by the person(s) I authorized in Section 1, but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the person(s) I authorized to receive and use health information described in Section 3. If patient (or personal representative) requested this Authorization , any revocation will be effective only when I communicate my revocation to them.

7. REDISCLOSURE. I understand that if the recipient of my information in Section 3 above is not a health care provider, a health plan, a health plan or health care clearing house or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws. If this Authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the substance abuse information under federal substance abuse confidentiality requirements.

8. CALIFORNIA/ARIZONA RESTRICTION. I understand that a recipient of medical information in California or Arizona may not further disclose medical information about me (patient) unless a new authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

9. RIGHT TO REFUSE TO SIGN. I understand that I do not have to sign this authorization.

10. AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified below.

End Date:_____or Event Name_____

11. COPY RECEIVED. I acknowledge receipt of a signed copy of this authorization_____(initial).

Date_____

_____

Signature of Patient (or personal representative, if applicable)

_____

Print name of personal representative (if applicable)

_____

Relationship to patient (if signature is anyone other than patient, describe signatory's relationship to patient)