Clinicas de Salud del Pueblo, Inc.

AUTHORIZATION FOR
USE, DISCLOSURE OR REQUEST
OF PROTECTED HEALTH INFORMATION

Failure to provide *all* information requested may invalidate this Authorization

Patient Name: _____ DOB_____MR#_____

I hereby authorize the use, disclosure or request of my health information as follows:

Person(s)/Organization authorized to **use or disclose** the information	Person(s)/Organization authorized to **receive** the information
To: CDSDP	To:
Address: City: State:	Address: City: State:
Phone: Fax:	Phone: Fax:

This Consent/Authorization applies to the following information (select one or more):

☐ Medical Records	☐ Mental Health Records (initials of pt. or rep required)
☐ Dental Records	☐ X-Ray Reports
☐ Other:	☐ HIV Lab Results (initials of pt. or rep required)

This authorization is for the period from _____to_____

This Authorization expires [insert date or event if left blank it expires in one year from today]: _____

My health information will be used for (select one): ☐ Patient request or ☐ Other (please explain) _____

_____

☐ If this box is checked, the Requestor will receive compensation for the use or disclosure of my information.

YOUR RIGHTS

You may request records be provided in the format of your choice: Paper, Electronic, other: _____.

The requestor of my information may not condition treatment, payment or health care operations on a signed authorization unless

- The authorization is for the provision of research-related treatment
- The purpose of the authorization is to permit the creation of information for the specific purpose of disclosure to a third party.

I may refuse to sign this Authorization or 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 following address: 651 Wake Avenue, El Centro, CA 92243. 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.

SIGNATURE: _____ DATE: _____
(Patient/representative, spouse, financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient: _____

Witness: _____Date:_____
First Name *Last Name*

If you have authorized the disclosure of your health information to someone not legally required to keep it confidential, it may be redisclosed and may not be protected. California law prohibits the requestor from making further disclosure of your health information unless the Requestor obtains another authorization from you or unless such disclosure is specifically required or permitted by law.