# CPS

**COMPREHENSIVE PSYCHIATRIC SERVICES**
***A Medical Group***

## AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

**I hereby authorize this medical practice to use and disclose health information specified below to:**

Recipient Name: _____

Recipient Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

**Health Information to be used or disclosed (check which applies):**

☐ All records dated from: _____ to _____ or ☐ Any/All previous treatment dates.

☐ Medical Records ☐ Psychological Testing Result ☐ Evaluations ☐ Treatment Plans ☐ Progress Notes

☐ Discharge Summaries ☐ Others: _____

**NOTE:** Records may include information related to mental health, alcohol or drug use.

I understand that this authorization is effective for one (1) year from the date of signature, **unless** a different date is specified here: _____

**NOTICE**: **Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal HIPAA Privacy Rule. Under California law, all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.**

Signature: _____ Date: _____

Relationship to Patient: _____