



## California Restrictions

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

## Your Rights

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment or health plan enrollment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to Health Information Services Department at this facility.
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.

## Redisclosure

I understand that if the recipient of my information is not a healthcare provider, a health plan or healthcare 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.

I have a right to receive a copy of this authorization.

If this box  is checked, a copy was requested and received. Initials \_\_\_\_\_

Phone#: Day \_\_\_\_\_ Message \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Personal Representative Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Witness \_\_\_\_\_

**ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.**



SAFH  SDH  SMCS  SRMC

**Authorization for Use or Disclosure of Health Information**

Patient Identification