San Diego American Indian Health Center
2630 1st Avenue
San Diego, CA 92103
619-234-2158

ACCT #: _____

# Authorization for Use and Disclosure of Protected Health Information

The privacy of your health information is protected. This form allows us to either send or receive information concerning your health, as detailed below.

**Your rights:** You have the right to inspect or copy information that is used or released under this authorization. You also have the right to refuse to sign this authorization. If you refuse to sign this form, it will not prevent SDAIHC from providing you with medical care unless the treatment is research-related or if it is treatment done for the sole purpose of providing the treatment information to another party (for example, having lab work performed as at SDAIHC for a doctor at another clinic). **Right to terminate or revoke authorization:** You may cancel (revoke or terminate) this authorization at any time by submitting a written request to the SDAIHC Medical Records Department.

**I hereby authorize** (person or organization who will **release** the health information):

☐ SDAIHC, 2630 First Avenue, San Diego, CA 92103 | Ph: 619-234-2158 | Fax: 619-487-9739, or

☐ **Person or Organization:** _____

**Address:** _____

**Phone #:** _____ | **Fax#:** _____

**To release information to** (person or organization who will **receive** the health information**:**

☐ SDAIHC, 2630 First Avenue, San Diego, CA 92103 | Ph: 619-234-2158 | Fax: 619-487-9739, or

☐ **Person or Organization:** _____

**Address:** _____

**Phone #:** _____ | **Fax#:** _____

**Information to be released include** (check all that apply)**:**

☐ Entire Record ☐ Immunizations ☐ HIV/AIDS related treatment ☐ Alcohol / Substance Abuse

☐ Other (specify) _____

☐ Psychotherapy Notes (by checking this box, I am waiving any psychotherapist-patient privilege).

**Purpose for release of health information:**
The information described above is being released for the following reason(s): _____

_____

**Expiration:** This authorization expires on: _____

**Potential for re-release (re-disclosure) of information:** I understand that once information is released by SDAIHC to the recipient noted above, we can no longer assure that the information will not be released again to a different party by the recipient noted above.

I agree that a photocopy or facsimile (fax) of this authorization will be as effective as the original. _____ (initials)

Patient Name (PRINT clearly): _____ DOB: _____

Signature of PATIENT: _____ Date: _____

Signature of Patient Representative: _____ Date: _____

Relationship to Patient: _____

Authorized information was released by: ☐ email ☐ fax ☐ mail ☐ in-person

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