FORM 16-11

Authorization for Disclosure of Health Information Pursuant to Evidence Code Section 1158

The undersigned authorizes the medical provider designated below to disclose specified medical records to a designated recipient. The medical provider shall not condition treatment, payment, enrollment, or eligibility for benefits on the submission of this authorization.

Medical provider: _____

Patient Name: _____

Medical record # (if known): _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone number: _____ Email: _____

Recipient

Recipient Name: _____

Recipient Address: _____

City: _____ State: _____ Zip code: _____

Recipient Telephone number: _____ Email: _____

Health information requested (check all that apply)

- ☐ Records dated from _____ to _____
- ☐ Radiology records:
- ☐ Images and/or films
- ☐ Reports
- ☐ Digital/CD, if available
- ☐ Laboratory results dated from _____ to _____
- ☐ Laboratory results regarding specific test(s) only (specify): _____
- ☐ All records
- ☐ Records related to a specific injury/treatment/other (specify): _____

_____

(continued)

NOTE: Records may include information related to mental health, alcohol/drug use, and HIV/AIDS. However, treatment records from mental health and/or alcohol/drug departments, and/or results of HIV tests will not be disclosed unless specifically requested below.

- ☐ Mental health records
- ☐ Alcohol/drug records
- ☐ HIV test results

Method of Delivery of Requested Records

- ☐ Mail
- ☐ Pickup
- ☐ Electronic delivery, recipient email: _____

Duration / Revocation / Redisclosure

This authorization is effective for one year from the date of signature unless a different date is specified here: _____ (date).

This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.

A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

Notice: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature

Patient Signature*: _____

Date: _____

Print Name: _____

*If not signed by the patient, please indicate relationship to the patient (check one if applicable):

- ☐ Parent or guardian of minor patient who could not have consented to health care.
- ☐ Guardian or conservator of an incompetent patient.
- ☐ Beneficiary or personal representative of deceased patient.