Harbor Psych
Harbor Psychologists and Office of Jorge Dubin, M.D.

Authorization for Use or Disclosure of Personal Health Information

EXPLANATION
This form is to allow the use of your medical information. It follows the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

AUTHORIZATION
By this I authorize (name of physician, hospital or health care provider):

To provide to (name of requestor):

Medical records and information referring to medical history, mental or physical condition, services provided, or treatment of (name of patient):

This authorization is limited to the following medical records and information:

USES
The requestor may use the approved medical information only for the following purposes:

DURATION
This authorization is effective immediately. It will remain in effect until (date): _____. I understand that any requests to revise or cancel must be in writing.

RESTRICTIONS
The requester may not share the health information without another written approval. Further use may occur if law specially requires it. Consent to treatment is not based upon signing this document.

Patient Name: _____

ADDITIONAL COPY

I am aware that I have a right to receive a copy of this document by requesting it.
Copy requested and received _____Yes _____No Initial _____

SIGNATURE

Date: Time: AM / PM

Printed Patient Name:

Patient DOB:

Signature:

If signed by another individual, indicate relationship to patient:

Witness: