IEHP
A Public Entity
Inland Empire Health Plan

Authorization for Use and/or Disclosure of Patient Health Information

Completion of this document authorizes the use and/or disclosure of your health information. Please read the entire document (both pages) before signing.

Patient Name:_____ Date of Birth:_____

Patient Address:_____

I hereby authorize:	**To release information (*specified below*) to:**
Inland Empire Health Plan (Health Care Provider / Organization to **release** information)	Shanda Y. Smith, PhD., LMFT, NCC (Health Care Provider / Organization to **receive** information)
PO Box 1800 (Address)	3400 Central Ave., Suite 310 (Address)
Rancho Cucamonga, CA 91729-1800 (City, state, zip code)	Riverside, CA 92506-2181 (City, state, zip code)
909-890-2054 (Phone Number) 909-890-5763 (Fax Number)	951-343-7193 (Phone Number) 951-682-1501 (Fax Number)

I authorize the release of the following health information *(select only one of the following)***:**

☒ All health information about my medical history, mental or physical condition and treatment received; OR

☐ Only the following records or types of health information (including any dates):

_____

_____

NOTE: The following types of information will not be released unless specifically authorized.

I specifically authorize the release of the following health information (*initials required if any of the following boxes are checked*)**:**

☒ Mental health treatment information Initial:_____

☐ HIV test results Initial:_____

☐ Alcohol / drug treatment information Initial:_____

Authorization for Use and/or Disclosure of Patient Health Information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.
PURPOSE: The requested use or disclosure of my health information is for the following purposes:

(1) To provide and coordinate my health care treatment and services; and
(2) To improve the quality of health care that I receive.

EXPIRATION: This Authorization expires one year from the date of my signature unless a different date is specified here _____ (*date*).

REVOCATION: I understand that I may cancel this Authorization at any time, but I must do so by submitting my request for revocation to the Health Care Provider / Organization authorized to release the information. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

NOTICE OF RIGHTS AND OTHER INFORMATION:

I understand that I do not have to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment or eligibility for benefits.

I understand that I have a right to receive a copy of this Authorization.

I further understand that information disclosed by this Authorization, may be redisclosed (given to) another person or agency and may no longer be protected by federal confidentiality law (HIPAA). However, California law does not allow the person receiving my health information by this Authorization to disclose it, unless a new authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I have read both pages of this Authorization and agree to the use and disclosure of health information specified above.

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of Patient's Legal Representative (if applicable) Date Signed

_____ _____
Print Name of Patient's Legal Representative Relationship to Patient