



Confidential Patient Information:
 See California Welfare and
 Institutions Code Section 5328

RESTRICTIONS

California law prohibits the requestor from making further disclosure of my protected health information unless the Requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

MY RIGHTS

I may refuse to sign this Authorization. I may inspect or obtain a copy of the protected health information that I am being asked to disclose. I have a right to receive a copy of this Authorization. I may revoke this Authorization at any time. My revocation must be in writing and sent to my primary clinic/clinical team.

My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization.

Treatment, payment, enrollment and/or eligibility for benefits will not be based on my providing, or refusing to provide, this Authorization.

Send my health information to:

Name _____
 Fax _____ Tel _____
 Address _____
 Email Address: _____

Client/Legal Representative

Signature/Name _____ **Date** _____
 Client/Legal Representative

If signed by someone other than the client, legal relationship to the client is: _____

Witness/Clinician Signature _____ **Date** _____

(California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.)