AUTHORIZATION TO RELEASE MEDICAL INFORMATION

* Indicates a REQUIRED field.

Limitations, if any: ____

(Per CMIA CA Medical Information Act - requires this authorization to include both the specific uses and the limitations, if any, on the use of the medical information by the person(s) or entities authorized to receive the medical information).

*Duration: This authorization shall become valid upon signature and shall expire on ________________ (please specify date, no longer than *one year* from date signed - *required*).

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: ____
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and ma no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure 2.8 (e)7.3 (s)215.8 (r)20726.197 -1.2