



Community Memorial Health System

Authorization for Use or Disclosure of Health Information Psychotherapy Notes

Patient's Name: _____ Birth Date: _____ MR#: _____ Bill#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone(s): _____

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

Failure to provide all information requested may invalidate this authorization.

NOTICE OF RIGHTS AND OTHER INFORMATION

1. I understand that this authorization is voluntary.
2. I may refuse to sign this authorization.
3. 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. I understand the Notice of Privacy Practices provides instruction should I choose to revoke my authorization.
4. I have a right to receive a copy of this authorization.
5. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might 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 is obtained from me or unless such disclosure is specifically required or permitted by law.
7. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
8. If this box is checked, the requestor will receive compensation for the use or disclosure of my information.
9. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to (address stamp):

I hereby authorize: _____
(NAME OF HOSPITAL / CENTER FOR FAMILY HEALTH)

CFH request; fax to: _____

to release to: _____
(PERSONS / ORGANIZATIONS AUTHORIZED TO RECEIVE THE INFORMATION)

Address: _____ City: _____ State: _____ Zip Code: _____

*Community Memorial Hospital • Medical Records / Health Information Department • 805/652-5047 • Fax 805/652-5649
Ojai Valley Community Hospital • Medical Records / Health Information Department • 805/640-2215 • Fax 805/640-1649
Centers for Family Health • Medical Records / Health Information Department • 805/652-5047 • Fax 805/652-5649*

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Community Memorial Health System

Authorization for Use or Disclosure of Health Information Psychotherapy Notes

This authorization applies to the following information:

Psychotherapy Notes

(include specific information regarding Psychotherapy Notes that you want released i.e. date, therapist, etc., below)

Date (s): _____

Therapist (s): _____

PURPOSE

Description of each purpose of request use or disclosure: _____

EXPIRATION

This is a onetime use Psychotherapy Note authorization and is not to be utilized for any dates of service past the date of the authorization.

After you have filled out this form, please print it and bring it to Medical Records at CMH to complete the request process.

SIGNATURE

Patient / Representative / Spouse / Financially Responsible Party: _____

Date: _____ Time: _____ A.M. / P.M.

If signed by someone other than the patient, state your legal relationship: _____

ID checked

I hereby authorize _____ to pick up my records.

ID checked

Hospital representative processing request: _____

Date: _____

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