AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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IMPORTANT NOTICE — CALIFORNIA PATIENT RIGHTS

- You may REFUSE to sign this authorization. Signing is strictly voluntary.
- Your treatment, payment, enrollment, or eligibility for benefits may NOT be conditioned on signing this authorization.
- You may REVOKE this authorization at any time in writing. Revocation does not affect actions taken before the practice received your written revocation. See Notice of Privacy Practices for details.
- If the recipient is not a health plan or health care provider, released information may no longer be protected by federal privacy law and may be redisclosed.
- You may inspect and obtain a copy of the information described on this form, for a reasonable copy fee, upon request.
- You will receive a copy of this authorization after you sign it.

SECTION A — PATIENT INFORMATION (Required for all authorizations)

Patient Name: _____ **Date of Birth:** _____

Phone Number: _____ **Last 4 Digits of SSN (Optional):** _____

SECTION B — PROVIDER / ENTITY AUTHORIZED TO DISCLOSE

Provider / Entity Name: _____

Address: _____ **Phone:** _____

SECTION C — PERSON / ENTITY AUTHORIZED TO RECEIVE INFORMATION

Recipient Name / Organization: _____

Recipient Address: _____

City: _____ **State / ZIP:** _____

Phone: _____ **Fax (physician/medical office only):** _____

Recipient Email: _____

SECTION D — PURPOSE OF DISCLOSURE

Select one:

☐ At the request of the individual

☐ Other third-party recipients please specify purpose:

Purpose: _____

Requested Dates of Service (From): _____ **To:** _____

Facility Name(s) and Address(es): _____

SECTION E — REQUESTED DELIVERY FORMAT

☐ Paper Copy
☐ Electronic Media (if available)
☐ Encrypted Email — Recipient email address confirmed above
☐ Unencrypted Email — See risk notice below

Unencrypted Electronic Delivery Risk: There is some level of risk that a third party could see your information without your consent when receiving unencrypted electronic media or email. The practice is not responsible for unauthorized access to the protected health information (PHI) contained in this format, or any risks (e.g., virus) potentially introduced to your device when receiving PHI in electronic format or email. If the requested electronic delivery method cannot be accommodated, an alternative delivery method (e.g., paper copy) will be provided.

SECTION F — AUTHORIZATION EXPIRATION (Select one only)

This authorization will expire after 180 days from the date signed, OR on the date or event specified below (choose one):

☐ 180 days from date of signature (default)
☐ Specific Expiration Date:

Expiration Date: _____

☐ Expiration Event:

Expiration Event Description: _____

SECTION G — DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

The recipient may use the disclosed information only for the purpose identified in this authorization and subject to any limitations stated in this form, unless otherwise permitted or required by law.

PSYCHOTHERAPY NOTES — IMPORTANT:
If you are requesting ONLY psychotherapy notes, check that box below and submit a separate authorization for any other records. Psychotherapy notes may NOT be combined with other record types on a single authorization.

☐ Psychotherapy Notes ONLY (submit a separate authorization for all other record types)

If NOT requesting psychotherapy notes, check any or all of the following that apply:

☐ All Pertinent Records (includes all listed below)
☐ Consultation Notes
☐ Discharge Summary
☐ Emergency Room Report
☐ EKG Report
☐ History & Physical
☐ Clinical / Lab Report
☐ Discharge Instructions
☐ Progress Notes
☐ Physician Orders
☐ Medication List
☐ Operative Report
☐ Pathology Report
☐ Problem List
☐ Radiology Report
☐ Labor & Delivery Record
☐ Specialty Test / Therapy Notes
☐ USCDI Release (requires Direct Address or NPI)
☐ Other (describe below):

Other Record Type (describe): _____

Sensitive Information Included in the Above Records

All types of information found in the records selected above will be provided (if applicable), including information that may be viewed as sensitive. Under

California and federal law, the following categories of information receive heightened protection:

☐ Alcohol / Substance Use Disorder Treatment	☐ HIV / AIDS Testing or Status	☐ Sexually Transmitted Infections (STI)
☐ Mental Health / Psychiatric Records	☐ Reproductive Health (including abortion, contraception)	☐ Intimate Partner Violence Services
☐ Genetic Information	☐ Gender-Affirming Care	☐ Immigration Status / Place of Birth (Cal. Civil Code § 56.10, SB 81)

CALIFORNIA LAW — IMMIGRATION STATUS & PLACE OF BIRTH (SB 81, eff. September 20, 2025):

Under California Senate Bill 81 (amending Cal. Civil Code § 56.10), a patient's immigration status (current or prior) and place of birth are protected "medical information" under the Confidentiality of Medical Information Act (CMIA). This practice is PROHIBITED from disclosing this information for immigration enforcement purposes, except:

- Pursuant to a valid search warrant or court order issued by a California state or federal court; or
- To the extent expressly authorized by the patient in writing; or
- As otherwise permitted or required by law (e.g., treatment, payment, or health care operations).

Specify any information below that you want to EXCLUDE from this release:

Exclusions: _____

CALIFORNIA LAW — SENSITIVE SERVICES EHR SEGREGATION (AB 352, eff. July 1, 2024):

California Assembly Bill 352 (amending Cal. Civil Code § 56.101) requires electronic health record systems to segregate records related to abortion, contraception, and gender-affirming care, and to restrict access to authorized personnel only. Records in these categories must not be transmitted outside California or in response to out-of-state

subpoenas. If you are requesting records that may include these categories, the practice will fulfill this request only to the extent permitted by applicable law.

SECTION H — MARKETING & SALE OF PHI (45 CFR § 164.508; Cal. Civil Code § 56.10)

Is this request for PHI for the purpose of marketing, or does it involve the sale of PHI?

☐ No — proceed to Section I

☐ Yes — complete the questions below (required before proceeding)

Will the provider receive financial remuneration in exchange for using or disclosing this information?

☐ Yes

☐ No

If yes, describe: _____

May the recipient of the PHI further exchange information for financial remuneration?

☐ Yes

☐ No

By signing below, I acknowledge that I understand the following:

- I may refuse to sign this authorization and it is strictly voluntary.
- My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but revocation will not affect any actions taken prior to receiving my written revocation. Further details may be found in the Notice of Privacy Practices.
- If the recipient is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
- I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

- I will receive a copy of this form after I sign it.

SECTION I — SIGNATURES (Cal. Civil Code § 56.11; HIPAA 45 CFR § 164.508)

I have read the above and authorize the disclosure of the protected health information as stated. I understand all notices set forth in this form.

ID Verified By (Staff Initials): _____ **Date:** _____

Signature of Patient / Patient's Representative: _____

Print Name of Patient's Representative: _____ **Date:** _____

Relationship to Patient: _____

Authority to Act for Patient (e.g., POA, Legal Guardian): _____

If you are not the Patient, mark your relationship(s):

☐ Spouse ☐ Legal Guardian ☐ Guarantor

☐ Parent ☐ Healthcare Power of Attorney ☐ Other (specify):

Other Relationship (specify): _____

FOR PRACTICE USE ONLY

Request Received By: Date Received:

Date Fulfilled:

Records Released By: Method of Delivery:

Notes:

Legal Authorities: California Confidentiality of Medical Information Act, Cal. Civil Code §§ 56–56.37 • SB 81 (2025), amending Cal. Civil Code § 56.10 (eff. 9/20/2025) • AB 352 (2023), amending Cal. Civil Code § 56.101 (eff. 7/1/2024) • HIPAA Privacy Rule, 45 CFR §§ 160 & 164.508 • Cal. B&P Code § 2290.5

This form is a compliance template. Each practice must review and adapt it to align with their Notice of Privacy Practices, EHR vendor capabilities, BAAs, and applicable Medi-Cal requirements prior to deployment.