| **HIPAA COMPLIANT AUTHORIZATION AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION/RECORDS** | Copies of this signed authorization will be considered as valid as the original. |
|---|---|

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

| | | | |
|---|---|---|---|
| ***I hereby Authorize:*** | | | |
| | Name of Disclosing Party | | |
| | | | |
| | Address | | |
| | | | |
| | City State Zip Phone | | |
| ***To Disclose To:*** | ***Lindsey & Associates 1279 W. Henderson # 207 Porterville Ca 93257*** | | |
| | ***Acting as an Agent of:*** | | |
| ***Records & Information Pertaining to:*** | | | |
| | Patient Name | Medical Record # | Date of Birth |
| | | | |
| | Address | | Phone |
| ***Duration:*** | This authorization shall become effective immediately and shall remain in effect until_____ or for one year from the date of signature. | | |
| ***Revocation:*** | This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My Written 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. | | |
| ***REDISCLOSURE***: | I understand that the requestor may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. | | |
| ***SPECIFY RECORDS*** | Check the box and initial to specify which type of information is to be disclosed. | | |
| | □ MEDICAL INFORMATION _____ Initial | □ PSYCHIATRIC INFORMATION _____ Signature _____ Date | |
| | □ DRUG/ALCOHOL INFORMATION _____ Signature _____ Date | □ RESULTS OF AN HIV BLOOD TEST _____ Signature _____ Date | |
| | □ OTHER HEALTH INFORMATION _____ (Specify Below) | | |
| ***Specify Records to be Disclosed:*** | | | |
| The Requestor may use the health information authorized on this form for the following purposes only: | | | |
| | | | |
| Date: | Signature: | | |