ARROYO VISTA FAMILY HEALTH CENTER

2411 N. Broadway Los Angeles, CA 90031 | Tel:(323) 987-2097
Email: healthinformation@arroyovista.org Fax: (323)987-1450

PATIENT INFORMATION		
LAST NAME:	FIRST NAME:	
DATE OF BIRTH:	MEDICAL RECORD #:	TELEPHONE #:
ADDRESS:	CITY/STATE:	ZIP CODE:

Person/Organization Providing the Information	Person/Organization Receiving the Information
Name: _____ Address: _____ City/State/Zip: _____ Phone # : (_____) _____ _____ Fax #: (_____) _____ _____	Name: _____ Address: _____ City/State/Zip: _____ Phone # : (_____) _____ _____ Fax #: (_____) _____ _____ ☐ Patient - Email:_____
45 C.F.R. §§164.508(c)(1)(ii), and (iii); CA Civil Code §§56.11(c), and (f)	

Description of the Information to be Released
(Provide a detailed description of the specific information to be released)
45 C.F.R. §164.508(c)(1)(i); CA Civil Code §§56.11(d), and (g)

Initial each type of confidential information you authorize to be released:

____ (Int.) HIV/AIDS/STD/Hep.C/ Test/ Results/ Treatment

____ (Int.) Substance Abuse

____ (Int.) Mental Health/ Behavior Health Information (Depression, Anxiety, etc.)

____ (Int.) Genetic Testing

____ (Int.) Other: _____

Provider Approved:_____ Provider Denied:_____ Date:_____

Other:

For the following period of time: from_____ (date) to_____ (date).

Description of the Purpose and Limitations for the Use or Release of the Information (Indicate how information will be used)
45 C.F.R. §164.508(c)(1)(iv)

The information will not be used for any purpose other than its intended use.

There will be a charge for a personal copy or the permanent transfer of your records. CIOX has been contracted by Arroyo Vista Family Health Center to provide this service and CIOX will charge you directly. For Questions Call CIOX at: (800) 367-1500 Select Site 10.

AUTHORIZATION FOR RELEASE OF INFORMATION

ARROYO VISTA FAMILY HEALTH CENTER

This authorization for release of information will expire in 12 months from the date signed or as otherwise specified: _____ (date).
[45 C.F.R. §164.508(c)(v); CA Civil Code §56.11(h)]

I understand that:

- **I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.** *[45 C.F.R. §164.508(c)(2)(i)]*
- **I have the right to cancel this authorization at any time by sending a signed notice to Arroyo Vista Family Health Center, Health Information Management Department at 2411 N. Broadway, Los Angeles, CA 90031. The authorization will cease on the date my valid revocation request is received.**
  [45 C.F.R. §164.508(c)(2)(i); CA Civil Code §56.15]
- **The Notice of Privacy Practices provides instructions for me should I choose to revoke my authorization and includes limitations on my revocation.**
  [45 C.F.R. §164.508(c)(2)(i)]
- **My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization.** ***[45 C.F.R. §164.508(c)(2)(ii)]***
- **Under California law, the recipient of my medical information is prohibited from disclosing the information, except with a written authorization or as specifically required or permitted by law.** *[CA Civil Code §56.13]*
- **If the organization or person I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.** *[45 C.F.R. §164.508(c)(2)(iii)]*
- **I have the right to receive a copy of this authorization.**
  [45 C.F.R. §164.508(c)(4; CA Civil Code §56.11(i)]
- **Records and copies obtained by recipient relating to outpatient psychotherapy care shall be returned to disclosing organization or destroyed by recipient at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.** *[CA Civil Code §56.104(a)(4)]*

Patient Signature:	Date:

[45 C.F.R. §164.508(c)(1)(vi); CA Civil. Code §56.11(c)]

Patient's (Personal) Representative Signature:	Relationship:	Date:

[45 C.F.R. §164.508(c)(1)(vi); CA Civil Code §56.11(c)]

ID Obtained and All Information Verified By AVFHC Employee:

_____ Date: _____

❑Lincoln Heights ❑Highland Park ❑ES Valley ❑ES Huntington

AUTHORIZATION FOR RELEASE OF INFORMATION