**UNIVERSAL RELEASE FORM**

Authorization to Use/Disclose

Protected Health Information (PHI)

**Client:**

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*Last Name, First Name, Middle Initial Date of Birth (Mo/Day/Year) Medi-Cal CIN or My Health LA ID #*

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*Street Address City, State, and Zip Code*

I permit the entities listed below to release, disclose, use, receive, and/or exchange my Protected Health Information for the purpose of coordinating my care and treatment.

1. **Identity of Entities Who May Share Information**

I authorize the following entities and their contracted healthcare providers participating in my treatment to share my health information with each other:

* My health plan **(*please check one as appropriate*):**

□ Anthem Blue Cross/Care More □ Health Net □ Care 1st

□ LA Care □Molina Health Care □ Kaiser Permanente

* LA County Department of Health Services (DHS)
* LA County Department of Mental Health (DMH)
* LA County Department of Public Health, Substance Abuse Prevention and Control (DPH-SAPC)
* LA County Department of Public Health, Division of HIV and STD Programs (DPH-DHSP)

1. **Description of Health Information**

I permit the entities listed in Section I to share any information in my medical file. This may include information related to my care or treatment; medical and pharmacy records; information related to my application for, enrollment in, and eligibility for health care services; information about the health care benefits I receive and claims that seek payment for these benefits; and other information necessary to coordinate my care and treatment.

By signing this Authorization, I specifically permit the entities listed in Section I to share my health information that relates to the following types of services I receive (if any)**:**

* Physical health
* Mental health
* Drug or alcohol abuse diagnosis, treatment, prognosis, or referral
* HIV/AIDS-related information, including AIDS-related complex (ARC)
* Genetic testing

**III. Expiration of Authorization**:

This Authorization will automatically expire one year after the date listed in the Client Signature section on page 3.

**IV. Other Important Information:**

By signing this Authorization, I understand that:

* I do not need to sign this Authorization in order to receive treatment or Cal MediConnect/ Medi-Cal benefits, enroll in Cal MediConnect/Medi-Cal, or for Cal MediConnect/Medi-Cal to pay for my health care.
* I have a right to receive a copy of this Authorization. A copy of this Authorization is as valid as the original.
* Entities that receive my health information under this Authorization may not be required to follow the same privacy rules as the entity that shared the information and could re-disclose my health information.
* However, if information related to drug or alcohol abuse or HIV/AIDS treatment is shared, that information cannot be re-disclosed except with another Authorization.
* I have the right to revoke this Authorization at any time in writing unless the entity disclosing my health information already shared my information before receiving my revocation. I may use the Revocation of Authorization at the bottom of this form to terminate this Authorization. Mail or deliver the revocation to your Health Plan.

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Once my Revocation of Authorization is received, my health plan will cancel the Authorization.

I have read and understand the content of this Authorization. I am signing the Authorization voluntarily, and understand that I have the right to refuse to sign the form. My signature authorizes the disclosure of the health information as described in this Authorization.

**Signature of Client or Client’s Legal Representative:**

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*Month Day Year*

If signed by Client’s Legal Representative, state relationship and authorityto do so:

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**Witness: Signature of Doctor, Providers, or Agency/Clinic Representative:**

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*Month Day Year*

*Street address City, State, Zip Code*

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| **Revocation of Authorization** |

I wish to revoke my authorization. (Please send to your Health Plan)

**Signature of Client or Client’s Legal Representative:**

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*Month Day Year*

If signed by Client’s Legal Representative, state relationship and authority to do so:

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