UNIVERSAL RELEASE FORM

AUTHORIZATION TO USE/DISCLOSE
PROTECTED HEALTH INFORMATION (PHI)

CLIENT:

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

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.

I. 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)

II. 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.

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:

_____ _____/_____/_____
Month Day Year

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

_____

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

_____ _____/_____/_____
Month Day Year

_____
Street address *City, State, Zip Code*

REVOCATION OF AUTHORIZATION

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

Signature of Client or Client's Legal Representative:

_____ _____/_____/_____
Month Day Year

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

_____