CONFIDENTIAL

AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL INFORMATION

[This document must be printed in 14-point type-face, pursuant to State Law]

I, _____, hereby authorize _____ to
(Name of Individual) (Name of person/facility which has the information)

release the following personal information: _____

_____

To:

_____
(Name and title or facility name to receive personal information)

_____ _____ _____
(Street address, city, state, zip code) (Telephone number) (Fax number)

For the following purposes: _____

_____

This authorization is in effect until _____ (date or event), when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable personal information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time except if you have already acted because of my permission. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the personal information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Individual:	Date

Or Signed by Personal Representative: _____	Date _____
On Behalf of _____ Name of Individual	_____

IDENTIFYING INFORMATION OF PERSON SIGNING FORM

☐ COPY OF IDENTIFICATION ATTACHED

TYPE _____ (DRIVER'S LICENSE, DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFITS IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER _____

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED

NOTARIZED BY _____

ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

NOT OFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

PERSONAL REPRESENTATIVE INFORMATION

WHAT LEGAL AUTHORITY DO YOU HAVE TO MAKE PERSONAL DECISIONS FOR THE INDIVIDUAL?

☐ PARENT ☐ CONSERVATOR

☐ GUARDIAN ☐ EXECUTOR OF WILL

☐ MEDICAL POWER OF ATTORNEY ☐ OTHER _____

NOTE: ATTACHING LEGAL DOCUMENTATION IS REQUIRED TO VERIFY THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE PERSONAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.

DEPARTMENT EMPLOYEE PROCESSING/MAINTAINING THIS AUTHORIZATION

(Name and title)

(Organization within Department) (Telephone number) (Mail Stop Number)

PRIVACY STATEMENT (CA CIVIL CODE SECTION 1798.17)

THE INFORMATION COLLECTED ON THIS FORM IS USED TO GET YOUR PERMISSION FOR THE USE OR DISCLOSURE, TO NON-DEPARTMENT PERSONS/ORGANIZATIONS, OF CERTAIN PERSONAL INFORMATION ABOUT YOU MAINTAINED BY THE DEPARTMENT. THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND ON FILE AT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, AS REQUIRED BY LAW. ALL INFORMATION REQUESTED ON THE FORM IS VOLUNTARY. NOT SUPPLYING THE INFORMATION REQUESTED WILL HAVE NO EFFECT ON YOU OR YOUR TREATMENT, PAYMENT, OR ELIGIBILITY FOR BENEFITS OR SERVICES FROM THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH. ANY INFORMATION PROVIDED MAY BE DISCLOSED TO THE CALIFORNIA STATE AUDITOR, THE CALIFORNIA OFFICE OF HEALTH INFORMATION INTEGRITY, THE CALIFORNIA OFFICE OF INFORMATION SECURITY AND PRIVACY PROTECTION, THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OR TO OTHER STATE AND FEDERAL AGENCIES AS REQUIRED BY LAW.

YOU HAVE THE RIGHT TO REVIEW THE RECORDS WE KEEP ABOUT YOU DURING NORMAL BUSINESS HOURS. THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH PRIVACY OFFICER WILL, UPON REQUEST, INFORM YOU REGARDING THE LOCATION OF YOUR RECORDS AND THE CATEGORIES OF ANY PERSONS WHO USE THE INFORMATION IN THOSE RECORDS. FOR MORE INFORMATION, CONTACT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, PRIVACY OFFICE, USING THE FOLLOWING CONTACT INFORMATION: CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, OFFICE OF LEGAL SERVICES, PRIVACY OFFICE, 1415 L STREET, SUITE 500 SACRAMENTO, CALIFORNIA 95814 OR BY PHONE 1-877-421-9634.