Anti-Aging Arts Medical Center
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619-543-1061/619-543-0043Fax

AUTHORIZATION FOR USE OR DISCLOSEURE OF PROTECTED HEALTH INFORMATION

Please read carefully and complete the reverse side of this form.
All sections of this authorization must be completely filled out before a medical office is permitted to disclose your protected health information.

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Please be aware that once your information leaves a medical office, that office will no longer be able to protect that information and the recipients of your information may not be legally required to protect your information.

NOTICE TO OCCUPATIONAL MEDICINE PATIENTS: California law allows your employer to access your health records only if you authorize the disclosure in writing, or for certain specific reasons. Some of the reasons include situations where your employer is required to do so by law, if you're involved in a lawsuit (or similar type process) with your employer where your medical history is at issue, where the information requested was requested or paid for by your employer, when the information is required to evaluate your need for medical leave or disability related benefits, or if it is necessary to administer your employee benefits plan. If you have questions or concerns about whether or not any of the above situations apply to you, please notify your provider before beginning any procedure and consider notifying our employer.

AUTHORIZAITON TO DISCLOSE SPECIFIC PROTECTED HEALTH INFORMATION: Federal and State laws require us to obtain specific authorization from patients to release sensitive information. Sensitive information is defined as treatment or documentation related to HIV AIDS test results; Psychiatric, Alcohol or Drug Abuse Treatment. Be aware that these types of information will be excluded unless you specifically identify them for release.

RESTRICTIONS: I understand that the establishment that has my records may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release__________________________ from any/all legal liability that may arise from the release of this information to the party named on the reverse side of this form.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request.

DURATION: I understand that I may revoke, in writing, this authorization at any time according to the instructions in the Anti-Aging Arts Notice of Privacy Practices, except to the extent that action has already been taken. Unless otherwise noted, this authorization will expire one year from the date of my signature.

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM