LINCOLN INTERNAL MEDICINE
801 STERLING PARKWAY, SUITE 120
LINCOLN CA 95648
(916) 408-3773 FAX: (916) 408-3853

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

I authorize: _____
(Name of person and or facility which has information)

_____
(Street address, City, State and Zip Code)

to release health information to: LINCOLN INTERNAL MEDICINE
801 STERLING PARKWAY, SUITE 120
LINCOLN CALIFORNIA 95648

Please specify the type of health information that you authorize to be released:
☐ MEDICAL ☐ MENTAL HEALTH (other than psychotherapy notes)

Type(s) of health information: _____

Date(s) of treatment: _____

The following information will not be released unless you specifically authorize it:

☐ I specifically authorize release of information pertaining to drug and alcohol abuse diagnosis or treatment (C.F.R. §2.34 and §2.35)

☐ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code § 120980 (g).

☐ I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j).

The purpose of this release is:

☐ At the request of the patient/patient representative

☐ Other (state reason): _____

Notice:

LIM and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentially laws.

Your Rights:

This authorization to release health information is voluntary. Treatment, payment, enrollment of eligibility for benefits may not be conditioned on signing this authorization except in the following cases: (1) to conduct research related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine the entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your representative and delivered to Lincoln Internal Medicine. The revocation will take effect when LIM receives it, except to the extent that LIM or others have already relied on it.

You are entitled to receive a copy of this authorization.

Expiration of Authorization:

Unless otherwise revoked, this authorization expires on_____ (insert applicable date or event).
If no date is indicated, the authorization will expire in 12 months from the date of my signing.

_____ _____
Print Name Signature (Patient, Parent, Guardian)

_____ _____
Date Time Relationship to Patient (i.e. Parent Guardian, Conservator, Patient Representative)

_____
Witness (only if patient is unable to sign)
Interpreter