Hybrid Health PAC

Patient HIPPA Consent Form:

In compliance with the Health Information and Accountability Act of 1996 (HIPPA) and California law, Hybrid Health PAC may not use or disclose your protected health information except as provided in our Notices of Privacy Practices without your authorization. Your completion of this form gives consent for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorized Hybrid Health PAC to use and disclose health information concerning:
Patient:_____DOB:____/____/____Date:_____

Health Information may be disclosed to:
Name (first and last):_____Relationship:_____
Name (first and last):_____Relationship:_____
Name (first and last):_____Relationship:_____
Name (first and last):_____Relationship:_____

Please mark the type of records that may be disclosed:

___: Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results,if any, except as specifically provided below.
___: All psychotherapy notes may be released, except as specifically provided below:
___: Claims/Billing Records
___: Other:_____

The information may be used for the following purposes:
___: at the request of the individual
___: Other:_____

"I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt."

"I understand that although federal law does not protect health information which is disclosed to someone other than another care provider, health plan or health care clearinghouse, under California Law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law."

"I understand that this form is only effective until one year after the date signed below."

I understand that I have a right to receive a copy of this authorization upon request.
Signature:_____Date:_____
Legal Guardian/Guarantor:
If not signed by the patient, please indicate the relationship:_____