OPSAM HEALTH
Caring for the Community Since 1973

HIPAA Authorization for the Use or Disclosure of Protected Health Information

Important

This HIPAA form authorizes the release of general medical, dental, and behavioral health treatment records, billing records, and other health information as requested below. Please complete all applicable sections of this HIPAA Authorization form.

If sections are incomplete or inconsistent this form may not be accepted. If this form has expired or has been revoked, it may not be used.

Psychotherapy notes are not included. Use the separate Opsam Health Psychotherapy Notes Authorization for psychotherapy notes.

1. Patient Information

Full Name: _____

Date of Birth: _____ Phone Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

2. Provider or Organization Authorized to DISCLOSE/SEND the Information

☐ Opsam Health

☐ Other provider or organization listed below

Name of disclosing provider/organization: _____

Address: _____

Phone: _____ Fax or secure email: _____

3. Person or Organization Authorized to RECEIVE the Information

☐ Opsam Health

☐ Other provider or organization listed below

Name of recipient: _____

Relationship to patient: _____

Address: _____

Phone: _____ Fax or secure email: _____

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4. Purpose of Request

The use or disclose is for the specific purpose(s) checked and described below:

- ☐ At the request of the individual
- ☐ For health care treatment, payment or health care operations
- ☐ Insurance, payment, or benefits administration
- ☐ Legal matters. Describe the matter and recipient use below.
- ☐ Other: _____

Specific purpose and recipient use/limitations:

_____

Additional limits requested by patient:

_____

5. General Records to Be Released and Dates of Services

Identify the time period for the requested records:
(Check only the records that may be disclosed)

- ☐ Entire medical and billing records for the date range above, except records excluded by law and sensitive information categories not specifically authorized in Section 6
- ☐ Medical visit notes, history and physicals, progress notes, assessments, and care plans
- ☐ Dental records
- ☐ Behavioral health treatment records, excluding psychotherapy notes
- ☐ Medication list and medication history
- ☐ Laboratory results
- ☐ Imaging, diagnostic studies, and reports
- ☐ Immunization records
- ☐ Referrals, consult notes, and care coordination records
- ☐ Billing, claims, payment, or eligibility records
- ☐ Other specific records: _____

6. Sensitive Records - Specific Authorization Required

I understand these categories may have extra protections under federal or California law.

Opsam Health will not release a sensitive category of information unless it is checked and initialed below, or unless disclosure is otherwise permitted or required by law.

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By checking and initialing the box(es) below, I agree that I am authorizing the disclosure of the specified records.

If the patient is a minor and the records involve services the minor could lawfully consent to, the minor may need to sign this authorization.

Initials Category:

_____ ☐ HIV test results. I specifically authorize release of HIV test results.

_____ ☐ Sexually transmitted infection or communicable disease records.

_____ ☐ Genetic testing records.

_____ ☐ Mental health treatment records, excluding psychotherapy notes.

_____ ☐ Substance use disorder treatment records, including records protected by 42 CFR Part 2.

_____ ☐ Medication for opioid use disorder or medication-assisted treatment records.

_____ ☐ Reproductive or sexual health records, including contraception, fertility, pregnancy, abortion, or abortion-related services.

_____ ☐ Gender-affirming care records.

_____ ☐ Sexual assault or intimate partner violence-related records.

☐ Minor-consented services records, only if signed by the minor or otherwise permitted by law.

_____ ☐ Other sensitive records specifically described here: _____

7. Expiration

California authorizations should include a specific expiration date. If the expiration date is left blank, Opsam Health may treat the authorization as incomplete or, only where legally permitted, as expiring 12 months after the date signed.

Unless revoked by the patient or a later expiration date is permitted by law, this authorization will expire on the date specified below or 12 months from the date signed, whichever occurs first.

Expiration date for this authorization:
(Example: MM/DD/YYYY.)

_____

If more than one year, reason or patient-specific request:

_____

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8. Please Read Before Signing

- I authorize the use or disclosure of my individually identifiable health information as described in this authorization.
- I understand this authorization is voluntary and that Opsam Health may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except if, and as, permitted by law.
- I may revoke this authorization at any time by submitting a written request to Opsam Health Medical Records at **637 3rd Avenue Suite E1, Chula Vista, CA, 91910**, by fax to **(619)-474-4008**, by email to **medicalrec@opsam.org** or portal location designated by Opsam Health. Revocation will not affect disclosures already made in reliance on this authorization before the revocation is received.
- Under California law, the recipient of medical information under this authorization may be prohibited from re-disclosing the information except with my written authorization or as specifically required or permitted by law.
- If the recipient is not a health plan, health care clearinghouse, or health care provider subject to HIPAA, the disclosed information may no longer be protected by federal HIPAA privacy rules. Other federal or California privacy laws may still apply.
- I have the right to receive a copy of this signed authorization. If Opsam Health seeks a copy of this authorization for the use or disclosure of my health information, I will receive a copy of the signed authorization and instructions for obtaining additional paper or digital copies.
- Reasonable copying, postage, or electronic-media fees may be charged only as permitted by applicable law.
- If any required element is missing, expired, known to be false, or inconsistent with the requested disclosure, Opsam Health may treat the authorization as invalid.

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9. Signature

By signing below, I confirm that I have read this authorization or had it explained to me, I understand it, and I authorize the use or disclosure of the information described above.

Printed name of patient: _____

Date of birth: _____

Date signed: _____

Phone: _____

Signature of patient: _____

If signed by someone other than the patient:

☐ Parent or legal guardian ☐ Conservator

☐ Health care agent or personal representative ☐ Other: _____

Description of legal authority to sign: _____

Documentation of authority reviewed, if applicable: _____

Signature of legal representative, if applicable: _____

Date signed: _____

Relationship to patient: _____

For Opsam Health Use Only - *Not Part of Patient Authorization*

☐ Patient identity verified

☐ Legal representative authority reviewed, if applicable

☐ Sensitive-content restrictions reviewed before disclosure

☐ Copy of signed authorization provided or instructions for copy access provided

Staff name: _____ Date received: _____ Date completed: _____