LOS ANGELES LGBT CENTER
Health Services

# Third Party Authorization for Use or Disclosure of Protected Health Information

*(For patients requesting copies of their own records, use HS 1350 - Patient Request for Access to Health Information form)*

By completing and signing this form, the patient authorizes the persons or agencies listed below to access or use the patient's protected health information, in compliance with California and federal health record privacy laws. **All questions must be answered before the Center can support the request.**

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**1.** Name _____ **2.** Birth date _____ **3.** Mother's Maiden Name _____

*I authorize the use or disclosure of my health information as described below.*

**4.** Person/organization authorized *to provide* the information

Name _____
Agency/organization _____
Address _____
City/state/ZIP _____
Telephone # _____
Email/Fax# _____

**5.** Person/organization authorized *to receive* the information

Name _____
Agency/organization _____
Address _____
City/state/ZIP _____
Telephone # _____
Email/Fax # _____

**6.** This authorization applies to the following information *(please mark all appropriate boxes in 6A and 6B :*

| 6A. General Authorization | 6B Specific Authorization |
|---|---|
| ❑ Visit Records (Medical, Psychiatry, and Mental Health) – No Alcohol/Drug Abuse Program Records<br>❑ Lab/Test Results X-Rays – No HIV results<br>❑ Medication Records/Lists<br>❑ Imaging Studies Visit<br>❑ Billing Records<br>❑ Appointment Information<br>❑ Other *(please describe)* _____ | ❑ Alcohol/drug Abuse Recovery Program Records<br>❑ HIV diagnostic test results<br>❑ HIV resistance testing results<br>❑ None of the above |

**7.** Format(s): ❑ Coordinate services and appointments by phone or in-person ❑ Physical records ❑ Verbal information

**8.** Purpose of use or disclosure:
❑ patient request *(option* **not** *valid if a health care provider or a health plan has requested the authorization)*
❑ other *(please describe)* _____

**9.** Authorization Expiration: ☐ Expires in One (1) Year ☐ Expires after (date): _____
☐ Only Canceled By Patient In Writing (see next page for instructions)

***ALL NINE (9) QUESTIONS MUST BE ANSWERED AND THE NEXT PAGE MUST BE SIGNED***

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## Notice of Rights

- I may refuse to sign this authorization. Los Angeles LGBT Center does not require me to complete this request in order to continue receiving care or services from it, except for research-related services. However, I understand that my ability to access benefits or services outside of the Center may be dependent upon my willingness to share my health information with other agencies.
- Under no circumstances am I required to authorize the disclosure of psychotherapy notes, HIV related information, and/or any participation in alcohol/drug abuse recovery programs.
- I can cancel this authorization at any time. I am aware that canceling must be done in writing, signed by me, and sent to Los Angeles LGBT Center, Attn: Health Services Medical Records, 1625 Schrader Blvd., Los Angeles, CA 90028. This authorization will be canceled after the Center gets my written cancelation notice. But, it will not apply to any information already used or disclosed before the Center received the cancelation notice.
- I have a right to receive a copy of this authorization. If it was not completed and submitted by me (the patient), I will be given a copy of it after I sign it.
- I understand that information accessed by the authorized person or agency might no longer be protected by federal privacy law (HIPAA) after it was used or disclosed. However, California law prohibits the person or agency from sharing my health information unless I authorize the disclosure or unless it is specifically required or permitted by law.
- I may inspect or obtain a copy of the information disclosed in writing pursuant to this authorization.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name patient's representative, if it applies Relationship to the client

***This section is for Los Angeles LGBT Center staff use, only.***

The undersigned confirm that they have reviewed a copy of the medical records requested by _____ to be provided to _____ and further confirm that the copied documents are a true and correct copy of the medical records of _____.

Staff Member Name: _____ Staff Member Signature: _____ Date: _____

Staff Member Name: _____ Staff Member Signature: _____ Date: _____