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.**

1. Patient's Name	
2. Patient's Birth date	
3. Patient's Complete Address	

I, the patient, 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	

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6. This authorization applies to the following information:

☐	Visit Records/Activity (Medical, Psychiatry, and Mental Health) – No Alcohol/Drug Abuse Program Records
☐	Alcohol/drug Abuse Recovery Program Records/Activity
☐	Lab/Test Results X-Rays – No HIV results
☐	HIV diagnostic test results
☐	HIV resistance testing results
☐	Medication Records/Lists
☐	Imaging Studies Visit
☐	Billing Records
☐	Other (please describe)

7. Person/organization authorized above will receive information in the following ways:

☐	Verbal information (for example, talking about my health or scheduling appointments).
☐	Paper copies mailed to the authorized person/organization.
☐	Copies emailed or faxed to the authorized person/organization.
☐	Other (please describe):

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. 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

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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: _____