



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: \_\_\_\_\_

**USE AND DISCLOSURE OF HEALTH INFORMATION**

I hereby authorize PEDES ORANGE COUNTY, INC to release to:

\_\_\_\_\_  
(Persons/Organizations authorized to receive the information)

\_\_\_\_\_  
(Address - street, city, state, zip code) (Phone) (Fax)

The following information:

- All health information pertaining to my medical history, mental or physical condition and treatment received; OR
- Only the following records or types of health information:  
\_\_\_\_\_

**PURPOSE**

Purpose of requested use or disclosure:  Patient request; OR  Other:

**EXPIRATION**

This authorization expires on (date): \_\_\_\_\_

**MY RIGHTS**

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Pedes Orange County, 4501 Birch Street, Newport Beach, CA 92660 OR Fax: 949-209-0407
- I have a right to receive a copy of this authorization

**SIGNATURE**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient/legal representative)

If signed by a person other than the patient, indicate relationship: \_\_\_\_\_

Print name: \_\_\_\_\_  
(legal representative)