

PATIENT NAME: FIRST / MIDDLE / LAST			DATE OF BIRTH	RECORD #
AKA (OTHER NAME)				
STREET ADDRESS	CITY	STATE	ZIP	AREA CODE PHONE # ()

I am the **PATIENT** **GUARDIAN** **CONSERVATOR** **DESIGNEE** and hereby authorize Natividad and or Facility Name: _____ to use or disclose health information of the above named individual **TO:**

SEND TO (NAME OF PERSON, ORGANIZATION, AGENCY)				
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STREET ADDRESS	CITY	STATE	ZIP	AREA CODE PHONE # ()
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PURPOSE: THE DISCLOSURE OF THESE RECORDS IS FOR THE FOLLOWING PURPOSE(S) ONLY

DATES & TYPE OF INFORMATION TO BE DISCLOSED:

Natividad policy is to provide all electronic records on a CD. If you are the patient requesting your own records, you may choose between printed copies or CD. Please check one: CD Print

RE-DISCLOSURE: If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law and a federal law governing drug abuse patient records prohibit recipients of your health information from re-disclosing such information, except with your written authorization or as specifically required or permitted by law.

INFORMATION TO BE RELEASED: This is a **full disclosure** authorization of health care information which includes health care maintenance records, and medical, surgical, sexually-transmitted disease, mental health, alcohol or other drug abuse care and treatment records, if any. This consent also authorizes the disclosure of HIV test results, if any. These records will be disclosed unless you specify information you wish excluded. Please initial below information you do not want released:

Exclude: _____ Exclude HIV test results
INITIAL

_____ **NO** Exclusions.

_____ Exclude Substance Abuse treatment information
INITIAL

_____ Exclude Mental Health treatment information
INITIAL

_____ Exclude other: _____
INITIAL SPECIFY

This Authorization is effective immediately and will remain in effect for one year or until (date or event) _____. I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address where I received care. My revocation will be effective upon receipt, but will not be effective to the extent that Natividad has acted in reliance upon this Authorization. I have a right to receive a copy of this Authorization. If I am being asked by Natividad to authorize this disclosure, I have a right to inspect or obtain a copy of such health information disclosed. I may refuse to sign this Authorization. Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.

DATE	PATIENT SIGNATURE	SIGNATURE OF HOSPITAL STAFF WHEN REQUESTED (AB610, MH)		
SIGNATURE OF PARENT, GUARDIAN, CONSERVATOR, DESIGNEE		RELATIONSHIP	EMPLOYEE NAME	DATE

Natividad
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FORM 7652 (5/19)

**AUTHORIZATION TO USE
OR DISCLOSE HEALTH
INFORMATION**



Patient Label

