



Public
Health

Brynn Carrigan - DIRECTOR
Kristopher Lyon, MD - HEALTH OFFICER



AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize Kern County Public Health Services Department:

to **release** information to: _____
OR
to **obtain** information from: _____

health information described below on : _____
(Patient name) (Date of birth)

for the purpose of: _____

This information is limited to the following type and duration of information:

☐ Medical Records	☐ Immunization Records
☐ Consultation Reports	☐ Radiology/Imaging reports
☐ Laboratory, Pathology Reports	☐ Any & all records for the last two years
☐ Other: _____	

I UNDERSTAND THAT:

- I understand that my right to healthcare is not conditioned on this authorization.
- I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and presented to the Custodian of Records. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I may inspect or copy the information to be used or disclosed as provided in CFR 164.524
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- A recipient of medical information in California may not further disclose medical information about me
- If I have questions about the disclosure of my health information, I can contact the Custodian of Records. I understand I have a right to receive a copy of this authorization.

Duration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in ONE YEAR.

***See reverse side for signatures**



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Signature of patient (or personal representative): _____

Print name of personal representative (if applicable): _____

Patient address: _____

Patient telephone number: _____

Witness signature (staff): _____

I acknowledge receipt of a signed copy of this authorization _____ (Patient initials)

**ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS
PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THE DISCLOSURE.**

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