HUMAN TOUCH
BEHAVIORAL HEALTH
WE CARE

HIPAA AUTHORIZATION FORM

Patient's Full Name _____ **Date** _____

Address _____ **Patient's Date of Birth** _____

City, State Zip Code _____ **Patient's Telephone Number** _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   Human Touch Behavioral Health (including affiliates, employees, agents and any additional person or facility listed on this document.)
   Providers Name/Person whom may receive information about me

   1610 Executive Ct.
   Address

   Sacramento, Ca 9564 P. (916) 359-2950 F. (916) 333-5970
   City, State Zip Code/Phone Number/Fax Number

3. The specific information that should be disclosed is:

   _____

   _____

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Human Touch Behavioral Health in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. This authorization expires one year from the date it was signed.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. Human Touch Behavioral Health charges $0.25 per page. You are required to pre-pay for the copies.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth**

OR, if applicable –

_____	_____	_____
Signature of Guardian or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this form is only provided when requested