## **AGC Health Benefit Trust**

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This Authorization is required for the Trust to release your health information to someone other than yourself or for purposes outside the Trust's normal operations (treatment, payment of claims or healthcare operations). Please read the following information carefully and complete the requested information below.

Name of Person whose health information will be disclosed	:
Date of Birth:/ Last	4 digits of Social Security Number:
Address:	
Phone Number: Ema	il address:
I AUTHORIZE AGC Health Benefits Trust to DISCLOSE	my health information TO THE FOLLOWING person(s) or
organization(s)	
At the following address:	
	y what information you authorize to be used or disclosed. The cords on file", or "Information related to my knee surgery"
For the date(s):	_ If no dates are specified the last 2 years will be provided
The following classes of information are protected by special may be restricted under certain circumstances. If you are recadditional authorization is required. Please initial each apple	questing access to records related to any of the following,
Mental health information Substance abuse Initial	treatment information HIV lab test results
<ul> <li>2. Describe the purpose or limitations of the request</li> <li>☐ At the request of the individual or personal repre</li> <li>☐ To a healthcare provider for continuation of care</li> <li>☐ Other:</li> <li>☐ I request that my health care records be delivered in an an</li></ul>	the following format (choose one):
	e one (1) year from the date of execution unless a different end

## **MY RIGHTS:**

Signature:

- 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 revoke this authorization at any time, but I must do so in writing and submit to Pacific Central Coast Health Center. My revocation will take effect upon receipt, except to the extent that others have taken action in reliance upon this authorization.
- I have a right to receive a copy of this authorization
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases may no longer be protected by federal confidentiality law (HIPAA).

Date:

Patient or personal representative)
ERSONAL REPRESENTATIVE
his section only needs to be completed if this authorization is being completed by someone as a personal representative
f the individual to whom the health information relates.
he Trust, for purposes of the Privacy Rule will treat a properly designated personal representative as the individual or purposes of the Privacy Rule. This will apply when the individual is deceased, the personal representative has been esignated in accordance with applicable law, or in the case of unemancipated minors, an authorization is required as result of state law. The Trust reserves the right to decline to recognize an individual as a personal representative if here is a reasonable belief that the individual whose information would be disclosed has been or could be subject to buse, neglect or endangerment by disclosure. Disclosure also will not be made if inconsistent with applicable law.
xcept as limited by state law or the Privacy Rules, no authorization is needed to disclose information to a natural parent r legal guardian of an unemancipated minor.
rint name of personal representative Relationship to individual
asis for being Personal Representative (e.g., legal guardian, executed health care power of attorney, etc.):
ttach documentation establishing your authority to act for the named individual.
.ddress:
hone Number: Email address:
ignature: Date:
**************************************
nternal Use Only:
☐ Identification verified for individual and/or personal representative
☐ Authorization reviewed and approved by
☐ Health Information disclosed date
☐ Signature of person who sent health information
☐ Scanned and uploaded to Simon