**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION MyMR**

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

**PATIENT INFORMATION**

Patient’s Name: Last First Middle Initial Birth Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Mobile phone#

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility MR# MyMR# Email

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Facility) to release protected health information to:

**USE AND DISCLOSURE OF HEALTH INFORMATION**Authorized to receive information: (Full Name of person or organization)

**MyMR (MyMR.com)**

In conjunction with releasing records to MyMR, please complete the section below for one additional provider you authorize Facility to release protected health information to via the MyMR application.

**USE AND DISCLOSURE OF HEALTH INFORMATION**

Authorized to receive information: (Full Name of person or organization) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELEASE:

All pertinent information including face sheet, physician dictated reports, medical and diagnostic reports.

Dates of Service: All dates that records were created at Facility unless cancelled by patient.

Method of disclosure: Electronically to MyMR.
Purpose: The protected health information is being used or disclosed for personal use and continuity of care.

Expiration: This authorization does not expire unless otherwise specified.

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

NOTICE OF RIGHTS AND OTHER INFORMATION

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 Facility address.

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
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 redisclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).
I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefit.

**SIGN BELOW:**

Date: Signature (patient/representative/spouse/financially responsible party)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by someone other than the patient, state your legal relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_