TARZANA TREATMENT CENTERS, INC.
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
Health Information Management

I authorize **Tarzana Treatment Centers, Inc.** to release health information to:

_____
Name of person or facility to receive health information

_____
Specify name/tide of person to receive heath information, if known

_____
Street Address, City, State, Zip Code

_____ _____
Contact Phone Number FAX Number

PATIENT PLEASE *INITIAL* EACH ITEM FOR INFORMATION TO BE RELEASED:

_____ Discharge Summary	_____ Treatment Progress Letter	_____ Billing Statements
_____ History & Physical	_____ Primary Care Clinic Records	_____ Attendance
_____ TB Test Results	_____ Dates of Treatment	_____ Laboratory Reports
_____Treatment Complete Letter	_____ HIV/AIDS Test Results/ Treatment Information	_____ Patient Progress in Treatment

_____Other: _____

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE:
☐ current treatment episode only ☐ past treatment episode
☐ dates from _____ to _____

THE **PURPOSE OF THIS RELEASE IS.** *(check one or more)*
☐ At the request of the patient/patient representative
☐ Other: (state reason) _____

Patient's Name (Print)	*Social Security #*	*Date of Birth*	*MRN*

Initials of Patient or Personal Representative	*Date*

PLACE LABEL HERE

Authorized Agent:
Knox Attorney Service, Inc./ Knox Services LLC.

NOTICE

Tarzana Treatment Centers, Inc. (TTC) and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.

I may revoke this authorization at any time, provided that I do so in writing and submit it to the Health Information Department of Tarzana Treatment Centers, Inc., 18646 Oxnard Street, Tarzana, California 91356. The revocation will take effect when TTC receives it except to the extent that TTC or other have already relied on it.

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I am entitled to receive a copy of this authorization, and I may inspect or obtain a copy of the health information that I am being asked to disclose.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____
(insert applicable date or event)

If no date is indicated, this Authorization will expire thirty (30) days after the date of discharge.

SIGNATURE(S)

Patient *or* **Patient's** ***Legal Representative (Signature)***	**Date**
	☐ AM ☐ PM
Name (Print)	Time
(If signed by someone other than the patient, state your relationship to the patient/authority.)	
Witness (Only if patient is unable to sign) or Interpreter	

Patient's Name (Print)	***Social Security #***	***Date of Birth***	***MRN***

PLACE LABEL HERE

Authorized Agent:
Knox Attorney Service, Inc./ Knox Services LLC.