This form is to allow the use of your medical information. It follows the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

AUTHORIZATION

I authorize College Health IPA (CHIPA) and

Name	Relationship	Phone Number	Fax Number

To share the information below with each other

- My Care Plan
- Care Plan Updates
- Prescribed medications and dosages
- Diagnosis and treatment progress
- Appointment status
- Other (describe)

USES

The information may only be used for care planning and coordination.

DURATION

This authorization is effective immediately. It will remain in effect until (date): _____.
I understand that any requests to revise or cancel must be in writing.

RESTRICTIONS

The requester may not share the health information without another written approval. Further use may occur if law specially requires it. Consent to treatment is not based upon signing this document.

ADDITIONAL COPY

I am aware that I have a right to receive a copy of this document by requesting it.
Copy requested and received _____Yes _____No Initial_____

SIGNATURE

Date: Time: AM / PM

Patient Name Printed: Patient DOB:

Signature:

If signed by other than patient, indicate relationship:

Witness: