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

Completion of this document authorizes the disclosure and use of health information about you.

Health coaches maintain the strictest levels of confidentiality. We require written authorization to release information regarding release of coaching information to anyone other than the client. By signing the authorization below, you are giving us permission to discuss the information regarding your health coaching with another individual (e.g. informing your healthcare provider(s) of the coaching process).

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for health coaching.



Name of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: **\_\_[the Coach]** \_\_\_ to release to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*[Persons/Organizations authorized to receive the information]*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *[Address — street, city, state, zip code]*

The following information:

􏰀Informing health care provider of health coaching process including providing a summary

􏰀All health information pertaining to my medical history, mental or physical condition and treatment received; OR

􏰀Only the following records or types of health information (including any dates):

b. I specifically authorize release of the following information (check as appropriate):

􏰀Mental health treatment information

(initial)

(initial) (initial)

Purpose of requested use or disclosure:

Limitations, if any:

EXPIRATION

This authorization expires on *(date)*: MY RIGHTS

􏰀Patient request; OR

􏰀Other:

* I may refuse to sign this authorization. My refusal will not affect my ability to obtain health coaching.
* I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
* I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

* I have a right to receive a copy of this authorization.
* Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may 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 for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.