ORANGE COUNTY
OC Community Resources
Our Community. Our Commitment.

Orange County Housing Authority
1501 E. St. Andrew Place • Santa Ana, CA 92705
(714) 480-2700 • California Relay Service (800) 735-2929
http://www.ochousing.org

HIPAA AUTHORIZATION

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By my signature hereon, I authorize any pharmacy/doctor /hospital to release my protected health information as identified and in the manner and/or to the person(s) indicated below.

PHARMACY/DOCTOR/
HOSPITAL LOCATION: _____

PATIENT'S NAME: _____ Tenant ID: _____

PATIENTS'S ADDRESS: _____

PURPOSE OF DISCLOSURE: ☐ At the request of the patient.
☐ Other (provide explanation): _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED: Verification of out-of-pocket medical expenses **NOT** covered by Medi-care, or insurance over the past 12–month period

I AUTHORIZE THE FOLLOWING TO **REQUEST** and **RECEIVE** PROTECTED HEALTH INFORMATION ON MY BEHALF INDICATED ABOVE: **Orange County Housing Authority (OCHA)**

***THIS AUTHORIZATION SHALL EXPIRE ON THE FOLLOWING DATE OR AT THE CONCLUSION OF THE FOLLOWING EVENT: _____ (mm/dd/yyyy) (THIS AREA MUST BE FILLED IN)**

I understand that my authorization, or refusal to provide additional Authorization(s), does not affect my ability to obtain treatment from the pharmacy. I may revoke this Authorization in writing at my time by sending a letter to the pharmacy or by completing the pharmacy's Authorization Revocation Form, except to the extent that the pharmacy has taken action in reliance on this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPPA privacy regulations.

_____ *I hereby represent and certify my initials here and signature below that I am the patient identified above and that I give this Authorization of my own free will, am competent by law to give such Authorization, and will hold Orange County Housing Authority (OCHA) and its affiliates and subsidiaries harmless from liability to their compliance with the provisions of this Authorization.*

_____*I hereby represent and certify by initials here and signature below that I am not the patient identified above, but provide this Authorization as a legal guardian, agent, representative, or executor of the patient on his/her estate. I represent by my signature below that I am legally or otherwise authorized to provide such Authorization on behalf of the patient. (Note: Proof evidencing legal authority is required.)*

SIGNATURE: _____ DATE: _____