

**GENERAL AUTHORIZATION FOR USE AND/OR DISCLOSURE OF
MEMBER/PATIENT HEALTH INFORMATION**

I hereby authorize _____
NAME OF DISCLOSING PARTY

ADDRESS

CITY STATE ZIP

To disclose to THE ECHO COMPANY
NAME OF RECIPIENT

P.O. BOX 340927
ADDRESS

SACRAMENTO, CA 95834
CITY STATE ZIP

Records and information pertaining to

NAME OF MEMBER/PATIENT (LIST OTHER NAMES USED) MEDICAL RECORD NUMBER DATE OF BIRTH

ADDRESS CITY STATE ZIP TELEPHONE NUMBER

DURATION: This Authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____.

REVOCACTION: This Authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this Authorization.

REDISCLASURE: I understand the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal policy regulations.

SPECIFY RECORDS:

Check the box and initial to specify which type of information is to be disclosed.

MEDICAL INFORMATION _____
INITIAL

PSYCHIATRIC INFORMATION

SIGNATURE DATE

DRUG/ALCOHOL INFORMATION

SIGNATURE DATE

RESULTS OF AN HIV BLOOD TEST

SIGNATURE DATE

OTHER HEALTH INFORMATION _____ (specify below)
INITIAL

Specify the records to be disclosed:

The recipient may use the health information authorized on this form for the following purpose:

******* COPY VALID AS ORIGINAL *******

Signature _____ Date _____

If signed by other than member/patient, indicate relationship _____