STATE OF CALIFORNIA

MEDICAL INFORMATION AUTHORIZATION

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DEPARTMENT OF PESTICIDE REGULATION
ENFORCEMENT BRANCH

I hereby authorize

PHYSICIAN OR HOSPITAL

ADDRESS

CITY, STATE AND ZIP CODE

to furnish to

NAME OF RECIPIENT OR RESPONSIBLE AGENCY

ADDRESS

CITY, STATE AND ZIP CODE

medical records, including my date of birth given below, and all information pertinent to medical care, treatment, hospitalization and/or outpatient care received by _____ (self, child, or ward) in regard to (describe incident):

which occurred in _____ County on (date or dates) _____

- I understand the purpose of providing this information is to assist in the investigation of the above incident, and for use in any associated legal or administrative action connected with the incident.
- I understand that this information will be used by the County Agricultural Commissioner's office in the above-listed county and by the Department of Pesticide Regulation. Such release will aid in the investigation of the incident described above.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws (HIPAA).
- This authorization expires a year after the date of signature, or as specified _____.
- Under the Information Practices Act of 1977 (California Civil Code section 1798, et seq.), the requestor may not disclose the medical information beyond the expiration of the authorization agreed to above unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law pursuant to state confidentiality laws.
- This authorization may be revoked at any time. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have received a copy of this authorization.
- A photocopy of this authorization may be used the same as the original.

AUTHORIZING SIGNATURE (MAY BE SIGNED INDIVIDUALLY OR AS PARENT OR GUARDIAN)	PATIENT'S DATE OF BIRTH	DATE
WITNESS		DATE

DISTRIBUTION: WHITE - FILE CANARY - PHYSICIAN OR HOSPITAL PINK - AUTHORIZING SIGNATURE OR PATIENT