El Dorado Community Health Centers
4327 GOLDEN CENTER DRIVE, PLACERVILLE CA 95667

MEDICAL TEL (530) 621-7700
MEDICAL FAX (530) 621-7713
DENTAL TEL (530) 497-5016
DENTAL FAX (530) 622-8908
www.edchc.org

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Print Patient's Name: _____

Patient's Date of Birth: _____ Phone: (_____) _____-_____

Mailing Address: _____

I AUTHORIZE EL DORADO COMMUNITY HEALTH CENTERS TO

□ Receive Records from □ Release Records to □ Exchange information with

Print Name or Facility:_____

Address: _____City: _____ State: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

PURPOSE OF THE REQUEST

□ Transfer Primary Care □ Consultation □ Personal Copy (fee required)

INFORMATION TO BE RELEASED

□ Complete Health Record (includes items below)
□ Progress Notes
□ Immunizations
□ Labs
□ Imaging (Reports Only)
□ Consult Reports
□ Pap
□ Colonoscopy
□ Dental
□ Other _____

Covering the last 5 years of health care or specified date range of _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/Aids and/or Genetic Testing Records Release

If my medical, dental or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, communicable diseases and genetics testing, I agree to its release. Initials _____

Unless revoked, this authorization will be valid until the information is released up to one year from the date of request. To revoke my authorization, I must submit my request in writing to health information services at the site where I submitted the authorization.

Signature: _____ Date: _____

Authority to sign if not patient: _____ Relationship to patient: _____