Authorization for Disclosure of Medical Record Information

Santa Cruz Community Health Centers
P.O. Box 542 Santa Cruz, CA 95060
Fax: 831-457-2486

REV 7/17

Patient Information

Patient Full Name: _____ Date of Birth: _____/_____/_____

Patient Address: _____ Home Phone: (_____) _____--_____

City: _____State: _____Zip: _____ Work Phone: (_____) _____--_____

Release or Obtain Information

I hereby authorize SCCHC to: (check one)

[ ] Release my medical record information to:	**[ ] Obtain information from:**
[ ] Patient will pick up records [ ] ECFHC [ ] SCWHC | [ ] Mail | [ ] Fax Name/Facility: _____ Attention: _____ Address: _____ Phone: (_____) _____--_____ City: _____ State:_____ Zip:_____ Fax: (_____) _____--_____	Name/Facility: _____ Attention: _____ Address: _____ Phone: (_____) _____--_____ City: _____ State:_____ Zip:_____ Fax: (_____) _____--_____

Purpose of Disclosure: [ ] Personal [ ] Continued Medical Care [ ] Legal [ ] Insurance [ ] Other_____

Information to be disclosed for the following date range _____ to _____

[ ] Entire Medical Record [ ] Immunization Record [ ] Laboratory Test(s) Only [ ] Billing Records

[ ] Other – please be specific, include dates, providers, labs/DI etc.:_____

Authorization to Release Protected Information

I specifically authorize release of the following information:

[ ] Mental Health Information	Initial:_____
[ ] HIV or AIDS Tests, Results & Related Information	Initial:_____
[ ] Sexually Transmitted Disease (STD)	Initial:_____
[ ] Alcohol and/or Substance Abuse Treatment Notes	Initial:_____
[ ] Genetic Testing	Initial:_____
[ ] Other:	Initial:_____

I understand:

*This Authorization is valid for one year unless you specify other wise (enter expiration date) _____. I may revoke this Authorization at any time by providing a written statement, except to the extent that the provider has already completed action on it. ** If I am the legally recognized representative of the patient I must provide supporting documentation. The information disclosed per this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA. 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. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on whether this authorization is signed. I have the right to a copy of this authorization.

_____ _____

Patient Signature **Date***

Know your Privacy Rights Refer to the HIPAA "Privacy Notice"

_____ _____

Parent/Legally Recognized Representative Signature** **Date****

Relationship: _____