Community Health Partners
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COMMUNITY HEALTH PARTNERS

Authorization to Release Protected Health Information (PHI)

Medical Record#:_____
Patient Name (print): _____ Phone: _____
Address (Street, City/State, Zip):_____
Date of Birth: _____ SSN (last 4 digits): _____

1. I hereby authorize that my protected health information be released from:
Clinic Name:_____
Address (Street, City/State, Zip): _____

2. I hereby authorize that my protected health information be released to:
Name of Organization/Person:_____
Address (Street, City/State, Zip): _____

3. Information to be Disclosed (tell us what information you need):
Information to be disclosed for the following date range _____to,_____
☐ Physician Report(s) and Test Result(s)
☐ Radiology Report(s) Only
☐ Radiology Image(s)–specify: ☐ X-Ray ☐ Ultrasound ☐ CT Scan
☐ MRI ☐ Mammography
☐ Laboratory Test(s) Only
☐ Complete Medical Record (all pages), excludes Radiology Images
☐ Billing Records
☐ Other (specify): _____

Note: A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

FOR OFFICE USE ONLY

Identification verified by (name): _____
Verified by (method): ☐ Photo ID ☐ Matching Signature ☐ Other:_____

4. Special Authorization (tell us if we have permission to release the following sensitive information):

I specifically authorize the release of the following information:

☐ Human Immunodeficiency Virus(HIV) test results _____ (initial)

☐ Alcohol/Drug Treatment Information _____ (initial)

☐ Mental Health Treatment Information _____ (initial)

☐ Genetic Test Results _____(initial)

5. Purpose of Requested Use or Disclosure (tell us how you will use the records):

☐ Continuation of Medical Care ☐ Personal Use ☐ Insurance

☐ Other (please list): _____

Limitations, if any: _____

_____

Requested Format (ONLY check one):

☐ Paper Copy ☐ Compact Disc(CD) ☐ MyChart/Online Portal

☐ Email (encrypted), provide email address:_____

☐ Email (unencrypted, note–if you request information to be sent via email unencrypted there is an increased risk information could be read by an unauthorized third party), provide email address: _____

☐ Other (must be agreed upon by the patient and provider): _____

6. Method of Release (ONLY check one):

☐ Mail ☐ Email ☐ Fax ☐ Pick-Up (if applicable) ☐ MyChart/Online Portal

7. Expiration:

This authorization shall become effective immediately and shall remain in effect for (1) year from the date signed unless a different date is specified here:_____ (initial) _____.

8. Your Rights:

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility benefits.

• I may inspect or obtain a copy of the health information I am being asked to allow the use or disclosure of.

• Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However,

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.

- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I revoke this Authorization for Release of Protected Health Information

Date of Revocation: _____ Signature:_____

- I have a right to receive a copy of this authorization.
- ☐ If this box is checked, Community Health Partners will receive compensation for the use or disclosure of my health information.

9. Signature (as required by law):

_____ _____ _____

Signature: (Patient / Representative / Guardian) Date: Time:

_____

If signed by other than patient, print name and indicate relationship to patient.

Authorized representative signing for the patient must also submit copies of the legal documents describing the personal representative's assignment of this authority.

_____ _____ _____

Witness Signature # 1 / Print Name / Title Date: Time:

_____ _____ _____

Witness Signature# 2 / Print Name / Title Date: Time:

(Witness Signature #2 required if patient marks with an "X".)

10. Interpreter Signature If Applicable:

I have accurately and completely read the foregoing document to:

_____

Patient / Legal Representative Name

In _____ , the patient's or legal representative's primary language. He/she understood all of the terms and conditions and acknowledged his/her agreement thereto by signing the document in my presence.

_____ _____ _____

Interpreter Signature / Print Name / Title Date: Time: