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SHASTA COMMUNITY HEALTH CENTER
HEALTH INFORMATION SERVICES
P.O. Box 992790
Redding, CA 96099-2790
(530)246-5759 FAX (530)246-5787

AUTHORIZATION TO RELEASE INFORMATION

This authorization is not valid if it has not been filled out completely. Please fill in all items.

Patient's Name: ______________________________ Phone #: ______________

AKA: ______________________________ Date of birth: ____________________

Address: ______________________________ ______________________________

S.C.H.C. Clinician__________________________ Chart #:_______________

Description of and/or limitation on information to be disclosed:

- ☐ immunization records
- ☐ recent and current problem list
- ☐ recent and current medication list
- ☐ recent history & physical
- ☐ all medical records
- ☐ progress notes from ____________________ to ____________________(dates)
- ☐ lab results from __________________ to ________________________ (dates)
- ☐ x-ray/ imaging/ diagnostic reports from _____________ to ______________ (dates)
- ☐ other: ____

Disclosure of information to be made **from:**
(name & complete mailing address)

____
____
____

Disclosure to be made **to**:
(name & complete mailing address)

____
____
____

Purpose of disclosure/ specific use of information: ______________________________
____
____

(over->)

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to cancel this authorization at any time. I understand that if I cancel this authorization, I must do so in writing and present my written cancellation to the Health Information Services Department. I understand that it will not apply to information that has already been released in response to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise cancelled, the disclosure of medical information is no longer authorized on ______________________(specific expiration date). When stating date, please allow enough time for processing request.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have copied the information to be used or disclosed, as provided in CFR 164.524. 1 understand that the information disclosed may be redisclosed and that the redisclosure may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the Health Information Services Manager at 246-5735.

I understand that I have a right to receive a copy of this Authorization form.

I understand that there may be a fee charged for processing this request.

_______________________________________ _______________________________________

[**Signature** of Patient or Legal Representative] **[Printed name** of person signing form]

____

[if signed by Legal Representative: relationship to patient or description of authority to act]

_______________________________________ _______________________

[Signature of Witness, if applicable] (**Date signed**)

This form complies with requirements of 45CFR1 64.508(c) & CA Civil Code §56.1 1

(Rev. 4/04)