Authorization to Release and Disclose Protected Health Information

Patient Information	Patient Name: _____ Date of Birth: _____ Address: _____ Alias/Nickname: _____ City: _____ State: _____ Zip: _____ Day Phone: _____
Clinic Health Care Provider (**Who** has the information you want released?) Please list the specific Provider and/or Clinic.	Clinic or Provider Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Fax#: _____ Day Phone:_____
Receiving Party (**Where** do you want the information sent?)	Name of Receiving Party: _____ Attention:_____ Address: _____ City: _____ State: ____ Zip: _____ Fax#: _____ Day Phone: _____
Information to be Released (**What** do you want sent or released? Check appropriate box.)	☐ Designated Record Set (records Including patient, demographics, health and billing records) –Last two (2) years. ☐ Date of service or records related to a specific illness (specify date of service or illness): _____ ☐ Any and all records in Designated Record Set – **Patient Initials**: _____ ☐ Other (specify record type): _____
Release of Sensitive Health Information	The health information released may contain Mental Health, Alcohol or Drug abuse, HIV or AIDS, Sexually Transmitted Disease, or Family Planning. **Please check one of the following and initial to release or not release this sensitive information that may be contained in your record: Release:** ☐ **or Not release:** ☐ **Initials** _____
Purpose of Release (**Why** is it needed? Why do you want it?)	Health care: ☐ Personal use: ☐ Legal: ☐ Insurance: ☐ Other – Please specify: _____
Release Instructions (**How** and **When** do you want the Information? **Who** do you want to pick up if not you and does CHC have valid documents on file?)	1. Release records by: a. ❑ Paper ❑ In person pickup ❑ Mail to receiving party ❑ Fax to receiving party ❑ Fax number: _____ b. ❑ CD/DVD ❑ In person pickup ❑ Mail to receiving party 2. If in person pickup, the person picking up the records is the ❑ Patient ❑ Parent/Family/Friend ❑ Legal Representative (must have appropriate documents on file with CHC) 3. Name of person picking up records: _____ Relationship to patient: _____ 4. Verify identity of person picking up records: Driver's License, Costco Card or Bank Card with Photo ID.

1. **Authorization is valid for one year after date signed unless you enter a different date or expiration here: Date:** _____
2. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
3. I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
   I also understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal regulations.
4. A fee is charged for some copies of healthcare information and must be paid in advance.
5. **MINORS 13-17**: A minors signature is required in order to release information regarding the following conditions: Reproductive care such as contraception, pregnancy (any age), sexually transmitted diseases (14 years and older), alcohol/drug abuse (13 years and older), and mental health (13 years and older).
   I consent to releasing the protected health information.

_____ _____ _____
Patient/Guardian/Power of Attorney Signature **Authority to Sign on Behalf of Patient (Document Required)** **Date**

AUTHORIZATION TO REVOKE RELEASE OF INFORMATION: _____ _____
Patient Signature Date