Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

☐ URGENT

Authorization to Release Health Records

Patient Name: _____ **Date of Birth:** ____/____/_____

Other names used: _____ **Other identifier:** _____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email (optional): _____

I hereby authorize: (check one)

☐ **Shasta Community Health Center** (SCHC) 1035 Placer St., Redding, CA 96001, Phone: (530) 246-5710, Fax: (530) 245-0705

☐ **Other:** _____
Name of person / entity to RELEASE health records

_____
Street Address, City, State, Zip Code Phone # Fax #

To release health records to (Recipient*): (check one)

☐ **Shasta Community Health Center** (SCHC) 1035 Placer St., Redding, CA 96001, Phone: (530) 246-5710, Fax: (530) 245-0705

☐ **Patient or Legal Representative**

☐ **Other:** _____
Name of person / entity to RECEIVE health records

_____
Street Address, City, State, Zip Code Phone # Fax #

*Recipient(s) may include individuals, entities with a treating provider relationship to patient, third-party payers, or other entities without a treating provider relationship patient. If recipient entity does not have a treating provider relationship to patient and is not a third-party payer, please indicate the name of the recipient entity, and: (1) the name(s) of individual participant(s), or (2) the name(s) of an entity participant(s) that has a treating provider relationship with the patient; or (3) a general designation** of an individual or entity participant(s) or class of participants that must be limited to a participant(s) who has a treating provider relationship with the patient whose information is being disclosed.

**When using such a general designation and disclosing information covered by substance use disorder information covered by federal regulations at 42 CFR Part 2 ("Part 2"), patient (or other individual authorized to sign in lieu of the patient) understands that, upon their request and consistent with Part 2, they must be provided a list of entities to which their information has been disclosed pursuant to such general designation.

Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

☐ URGENT

Patient Name: _____ **Date of Birth:** ____/____/_____

Please **DESCRIBE** the **PURPOSE** of the disclosure as specifically as possible:

_____

_____

Date range of information to release: _____ **to** _____

What information would you like shared?	
☐ Immunization (shot) records	☐ Colonoscopy / Pathology
☐ Current medication list	☐ Current problem list
☐ Office visit notes / CHDP / Well Child exam	☐ Hospital reports
☐ Lab results	☐ X-ray / Imaging / Diagnostic Reports
☐ Pap / Pathology / HPV	☐ Retinal / Diabetic Eye Exam
☐ Specialist consultation reports	☐ Other: _____

I approve the release of the following protected or sensitive information: (initial REQUIRED)

_____ Mental Health _____ Psychotherapy notes _____ HIV test results

_____ Substance Use Disorder records (covered by 42 CFR Part 2 ("Part 2") ("Confidentiality of Substance Use Disorder Patient Records")) **Please answer the following:**

Please **DESCRIBE HOW MUCH** and **WHAT KIND** of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed:

_____

_____

_____

➔ **Notice:** Fees may apply for copies of your records. _____ **(initial)**

➔ I understand the organization I am requesting FROM may only accept this release via email, which is not a guaranteed form of secure communication. _____ **(initial)** (Kaiser / Other)

Shasta Community Health Center
a californiahealth+ center

MRN: _____

Employee ID #: _____
Office Use Only

☐ URGENT

Patient Name: _____ **Date of Birth:** ____/____/_____

Your Rights: This authorization to release health information is given freely. I understand that I may refuse to sign this authorization and further understand that I need not sign this form in order to be treated at SCHC. I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that any such revocation is in writing and provided to SCHC's Health Information Services (HIS) Department. SCHC may not condition my treatment on my signing this form. A photocopy or fax of this authorization is as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I know I can look at or get copies of the information that's being shared. This right is given by 45 CFR 164.524. I know if I give approval the information shared with SCHC may be shared again with another medical center. This may not be protected by federal confidentiality rules.

I am signing this authorization voluntarily and that my treatment will not be affected if I do not sign this authorization. (45 CFR 164.508 c2ii)

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Unless required by law, California law prohibits the Recipient from further disclosing your health information unless the recipient obtains another authorization from you. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I know if I have questions about sharing my health information, I can call SCHC Medical Records at (530) 246-5758.

Expiration of Authorization: Unless otherwise revoked, this authorization expires ___/___/_____. If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

Signature: _____ **Date:**_____

If Legal Representative (List relationship to the patient or why you have authority to sign):

Printed name: _____ **Relationship:** _____

Witness (if needed): _____

Office Use Only: (initial/date) *ROI Faxed/Sent:* _____ *PHI log:* _____

Released by: _____ *Preferred Delivery: (circle) Paper / CD / Mail / Pick Up / Fax / Electronic*