AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

1179 North McDowell Blvd., Petaluma, CA 94954
Phone: (707) 559-7500 Fax: (707) 559-7620

DATE: _____ **PATIENT NAME:**_____ **DOB:** _____
ADDRESS: _____ **PHONE:**_____

Purpose: The purpose of requested use or disclosure:

- ☐ Patient requesting copy of records for self.
- ☐ Patient requesting copy of records for another provider for continuity of care.
- ☐ Patient authorizing disclosure of health information to another person.

Release FROM Petaluma Health Center - I authorize PHC to release the following information:

- ☐ Complete Health Record (last 2 years unless noted otherwise)-***DOES NOT INCLUDE*** *the following; subject to confidentiality protections*
  - ☐ Release Mental Health/Behavioral Health Information _____ (initial)
    - ☐ Release Psychotherapy notes for continuity of care _____ (initial)
  - ☐ Release Treatment for Alcohol and/or Drug Abuse _____ (initial)
  - ☐ Release HIV or AIDS Information _____ (initial)
- ☐ Only records from: date _____ to date _____
- ☐ Only for a specific visit/procedure _____
- ☐ I authorize disclosure of health information to _____ Relationship_____

This information will be released to:
Name/Doctor/Medical Facility: _____ Phone: _____
Address: _____ Fax: _____

Release TO Petaluma Health Center - I authorize the below mentioned to release the following information:
Name/Doctor/Medical Facility: _____ Phone: _____
Address: _____ Fax: _____

- ☐ Complete Health Record-*DOES NOT INCLUDE the following; subject to confidentiality protections*
  - ☐ Release Mental Health/Behavioral Health Information _____ (initial)
    - ☐ Release Psychotherapy notes for continuity of care _____ (initial)
  - ☐ Release Treatment for Alcohol and/or Drug Abuse _____ (initial)
  - ☐ Release HIV or AIDS Information _____ (initial)
- ☐ Only records from: date _____ to date _____
- ☐ Only for a specific visit/procedure _____

The information will be released to:
- ☐ Urgent - Fax to: (707) 559-7620
- ☐ Mail: PHC, 1179 N. McDowell Blvd. Petaluma CA 94954

My Rights:

- I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this Authorization at any time, but I must do so in writing and submit it to the following address: Petaluma Health Center, 1179 No. McDowell Blvd., Petaluma, CA 94954.
- My revocation of a prior Authorization will take effect upon receipt, except to the extent that others have acted in reliance upon that Authorization.
- I may inspect or obtain a copy of the health information that I am authorizing to be disclosed.
- Information disclosed pursuant to this Authorization could be redisclosed by the recipient. Such re-disclosure might not be protected by California law or federal HIPAA law, depending on the circumstances. Confidentiality of Medical Information Act (CMIA) prohibits such re-disclosure without a new written authorization except as specifically permitted or required by law (California Civil Code Subsection 56.13).

Duration: This authorization is effective immediately and remains in effect for one year from this date of signature unless a different date is specified here _____(date).

Charges: I understand that you may charge me a reasonable charge up to 25 cents ($.25) per page for photocopies. Also, any additional reasonable clerical costs incurred in making the records available and any postage costs incurred for mailing the records may be charged to me.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized here in.

_____ _____ _____/_____/_____

SIGNATURE **If signed by Guardian/Other, Indicate Relationship** **DATE**

Date received:
Processed by: