One Community Health
Healthy Together.

RELEASE OF INFORMATION

(Authorizing us to discuss health information with friends, family or others)

Disclosure of Medical Information: Your medical information and communication of that information is essential to your care. We prefer to speak to you as our patient but we understand that family members or others may need knowledge of and be assisting in your care. By completing this form, you are authorizing us and our staff and/or providers to discuss your care with the organization or individuals you listed below.

1. Patient Information:

Patient Name	Date of Birth	Phone Number

2. I authorize One Community Health to discuss/share protected health information about me with the following individual(s) who are involved in my care:

Name of Person/Organization	Relationship to Patient	Phone Number

3. Type of information to be shared or disclosed:

□ Appointment Information
□ Medication Pick Up
□ ALL information, including medical, mental health, case management, or service related records pertaining to medical history, including HIV antibody test results, HIV-related conditions, substance and alcohol use, mental or physical condition, or other services rendered at One Community Health.
□ Other:_____

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 understand that this authorization for disclosure of information will become effective as of the date entered below and will remain in effect for ONE YEAR.
- I have a right to request and receive a copy of this form.
- I may revoke this authorization at any time but I must do so in writing to: *One Community Health, Attn: Health Information Management, 1500 21st Street, Sacramento, CA 95811* or by completing a Revocation Form available at One Community Health. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.
- I understand that re-disclosure of my medical information by those receiving the above authorized information may be accomplished without my further authorization or knowledge and that One Community Health is in no way responsible for such re-disclosure. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURES: I understand what I am signing, and have had any questions concerning this matter answered to my satisfaction.

Signature of Patient/Authorized Individual	Date