One Community Health
Healthy Together.

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR PROTECTED HEALTH INFORMATION

PATIENT INFORMATION		
Name:	Medical Record #:	
Birthdate:	Phone Number:	Request Date:

PROTECTED HEALTH INFORMATION MAY BE DISCLOSED BY:		
Person/Facility:	Phone:	Fax:
Address:		

PROTECTED HEALTH INFORMATION MAY BE DISCLOSED TO:		
Person/Facility:	Phone:	Fax:
Address:		

FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED

- ☐ Paper
- ☐ Electronic Media

PREFERRED METHOD OF DELIVERY

- ☐ Pick up at One Community Health
- ☐ Mail to Address Listed Below
- ☐ Release to MYCHART Account
- ☐ Email to: ________________________ ☐ *Encrypted* ☐ *Unencrypted*

The health information will be sent via encrypted email unless I specify otherwise. By requesting unencrypted email, I acknowledge there is some risk that my health information could be accessed by a third party.

PROTECTED HEALTH INFORMATION TO BE DISCLOSED

Specify records to be released and /or disclosed:

- ☐ General Medical Information (from _____to _____)
- ☐ Information Regarding Specific Injury or Treatment (from _____ to _____)
- ☐ X-Ray/Laboratory Results of (from _____ to _____)
- ☐ Mental Health* (from _____ to _____) Required Initials ______________
- ☐ Alcohol/Drug** (from _____ to _____) Required Initials ______________
- ☐ HIV Test Results (from _____ to _____) Required Initials ____________
- ☐ Other (Specify)_____________

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YOUR RIGHTS

YOUR RIGHTS

This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this form. I understand that I may revoke this authorization in writing at any time. I understand my revocation will NOT affect any disclosures that occurred before One Community Health received and processed a written notice of revocation.

I understand that if I do not specify a duration and if I do not revoke it, this authorization will automatically expire one year from the date of signature below. Unless otherwise revoked, this authorization expires _________ (insert date).

To revoke this authorization, I understand that I must send a written request to One Community Health, ATTN: Health Information Management, 1500 21st Street, Sacramento, CA 95811.

I am entitled to receive a copy of this authorization.

NOTICE

Fees may apply for copies of your records. 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. Processing records may take up to 15 days or as required by law.

SPECIAL RECORDS

*__Rights regarding Mental Health information__: A separate authorization form must be completed to authorize the disclosure or use of psychotherapy notes, as defined under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. pts 160 & 164. With certain exceptions, you have the right to inspect/receive a copy of your personal health information. In limited circumstances we may deny you access to your own mental health information if your provider determines this may cause harm. If you are denied access, you have the right to have your denial reviewed.

**__Rights regarding substance use disorder records__: Substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2 and HIPAA, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

THIRD PARTY SHARING

It is important to note that once you request that we share your protected health information with a third-party application or you request your healthcare provider to share your protected health information with a third-party application, One Community Health is not responsible or liable for any subsequent use or disclosure of the data.

AUTHORIZATION

I authorize the disclosure of my protected health information to the person(s)/entity(ies) described on this form. I understand this authorization is voluntary and that once information is disclosed, it may be re-disclosed and no longer protected by privacy regulations. I have had the full opportunity to read and consider the contents of this authorization, and I hereby give permission to One Community Health to release and disclose my protected health information as described in this request. I understand that One Community Health will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

By:______________________ ____________________ __________

Patient's Name (Print) Signature Date

If you are not the patient, please also complete, sign and date below.

By: _____________________ ____________________ __________

Legal Representative's Name Signature Date

Relationship to Patient ____________________________

Required:

STAFF USE ONLY: Name of staff member verifying patient identity (print clearly):

____

OFFICE USE ONLY:

Request fulfilled by: ______________________________ **on** _____________________

HIM Employee **DATE**

Provided in preferred format selected above ☐ **Yes** ☐ **No**
Sent via preferred method of delivery selected above ☐ **Yes** ☐ **No**
If not, why?____