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:		

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)_____

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 did not specify duration and if I do not revoke it, this authorization will expire one year from the date of signature below. 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.

You are entitled to receive a copy of this authorization. Unless otherwise revoked, this authorization expires _____ (insert date). If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

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. Your Rights:

SPECIAL RECORDS

*Rights regarding Mental Health information: 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 the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Acknowledgement

I authorize the disclosure of my protected health information to the persons/entities described in this request. I understand this authorization is voluntary and that once information is disclosed, it may be re-disclosed and no longer protected by federal privacy regulations. I hereby give permission to One Community Health to disclose my protected health information described in this request.

I have had the full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to One Community Health to release non-public protected health information. 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 patent, please also complete, sign and date below.

By: _____ _____ _____

Representative's Name Signature Date

Required:

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

_____