One Community Health
Healthy Together.

PATIENT NAME:____________________________________

DATE OF BIRTH:______________ **MRN:**_______________

Address:____

City:_________________ **State:**____**Zip Code:**__________

Phone #:____

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

I hereby authorize:

Name of Person/Facility: ____

Street Address, City, State, Zip Code:________________________________

Phone: ______________________________ Fax: ______________________________

To release information to:

Name of Person/Facility: ____

Street Address, City, State, Zip Code:________________________________

Phone: ______________________________ Fax: ______________________________

Types of Health Information you authorize to be released for the following range:______________**to:**_________________

- ☐ Medical (May include drug/alcohol/mental health info documented by primary care provider)
- ☐ Mental Health***** (May include drug/alcohol/mental health info documented by psychiatrist)
- ☐ Medication list
- ☐ Dental records
- ☐ Pharmacy records
- ☐ Billing records
- ☐ Other:____

The information below is protected by law and will not be released unless you specifically authorize:

- ☐ I specifically authorize the release of **HIV/AIDS test results**
- ☐ I specifically authorize the release of **Drug/Alcohol Abuse Treatment** records (42 CFR Part 2)
- ☐ I specifically authorize the release of **Mental Health Treatment** records

Delivery method preference: ☐ Mail ☐ Fax ☐ Pick-up ☐ Secure E-mail

Purpose of this release is for: ☐ At patient request ☐ Other: ______________________________________

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:** This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this form. You may revoke this authorization at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: Health Information Management Dept., One Community Health, 1500 21st Street, Sacramento CA 95811. The revocation will take effect when One Community Health receives it, except to the extent One Community Health or others have already relied on it. 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. ***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.

____________	____________________	__________________________	____________________
Date	**Print Name**	**Patient/Patient Rep Signature**	**Relationship to Patient**