



Patient Name: \_\_\_\_\_

Date of Birth: \_\_/\_\_/\_\_

**What Information would you like shared?**

Date range of information to release: \_\_\_\_\_ to \_\_\_\_\_

<input type="checkbox"/>	Immunization (shot) records	<input type="checkbox"/>	Colonoscopy / Pathology
<input type="checkbox"/>	Current medication list	<input type="checkbox"/>	Current problem list
<input type="checkbox"/>	Office visit notes / Well-Child	<input type="checkbox"/>	Hospital reports
<input type="checkbox"/>	Lab results	<input type="checkbox"/>	X-Ray / Imaging / Diagnostics
<input type="checkbox"/>	Pap / Pathology / HPV	<input type="checkbox"/>	Retinal / Diabetic Eye Exam
<input type="checkbox"/>	Specialty consultations	<input type="checkbox"/>	Other: _____

**I approve the release of the following protected or sensitive information:**

(Initial for each type of information)

_____ Mental Health	_____ Psychotherapy Notes	_____ HIV testing
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\_\_\_\_\_ Substance Use Disorder records (covered by 42 CFR Part 2 ("Part 2") ("Confidentiality of Substance Use Disorder Patient Records")) Please answer the following:

Please **DESCRIBE HOW MUCH** and **WHAT KIND** of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

➔ **Notice:** Fees may apply for copies of your records. \_\_\_\_\_ **(initial)**

➔ I understand the organization I am requesting FROM may only accept this release via email, which is not a guaranteed form of secure communication. \_\_\_\_\_ **(initial)**

**Your Rights:** This authorization to release health information is given freely. I understand that I may refuse to sign this authorization and further understand that I need not sign this form in order to be treated at SCHC. I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that any such revocation is in writing and provided to SCHC's

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Health Information Services (HIS) Department. SCHC may not condition my treatment on my signing this form. A photocopy or fax of this authorization is as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I know I can look at or get copies of the information that's being shared. This right is given by 45 CFR 164.524. I know if I give approval the information shared with SCHC may be shared again with another medical center. This may not be protected by federal confidentiality rules.


I am signing this authorization voluntarily and that my treatment will not be affected if I do not sign this authorization. (45 CFR 164.508 c2ii)

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

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.

I know if I have questions about sharing my health information, I can call SCHC Medical Records at (530) 246-5758.

**Expiration of Authorization:** Unless otherwise revoked, this authorization expires \_\_/\_\_/\_\_\_\_. If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

Patient Name (Print):	Date:
 <b>Sign Here:</b>	
Relationship: <input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Guardian/Legal Representative <input type="checkbox"/> Foster Parent	
If signing for the patient, print your name:	

<b>Office Use Only:</b> (initial/date)
ROI Faxed/Sent: _____ PHI Log: _____ Released by: _____
Preferred Delivery: (circle) Paper / CD / Mail / Pick-Up / Fax / Electronic