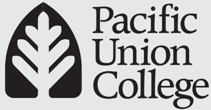
RELEASE OF HEALTH INFORMATION



Health Services
Angwin, CA 94508
707-965-6339
707-965-6243 (fax)

Date: ____________________

Patient:

Name of patient/previous names: ____________________

Birth date/Medical record number: ____________________

Address: ____________________

Phone: ____________________

Authorizes:

Name of health care provider/plan/other: ____________________

Address ____________________

Phone: ____________________ Fax: ____________________

Release of Protected Health Information to:

Name of health care provider/plan/other: ____________________

Address ____________________

Phone: ____________________ Fax: ____________________

Information to be Released:

- ___ Alcohol/Drug Assessment Summary, including testing
- ___ Allergy Records
- ___ Consultations
- ___ Entire Record
- ___ Entire Record & Mental Health Records
- ___ Hospital Records including Report
- ___ Immunizations
- ___ Laboratory Reports
- ___ Medical History, Examination, Reports
- ___ Mental Health Records
- ___ Prescriptions
- ___ Surgical Reports
- ___ Treatment or Tests
- ___ X-ray Reports
- ___ Other (Specify): ____________________ ____________________

Purpose for Need of Disclosure: *(Check applicable categories)*

- ___ Changing Physicians
- ___ Further Medical Care
- ___ Insurance Eligibility/Benefits
- ___ Legal Investigation or Action
- ___ Personal
- ___ Other (Specify): ____________________ ____________________

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

I understand that my express consent is required to release any health information related to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use. Pacific Union College is specifically authorized to release all health care information relating to such diagnoses, testing, or treatment.

This authorization conforms to federal regulation promulgated under 43CFR, Part 2, Subpart C and WAC 275-56-240. Records obtained as authorization by this consent for information release will be maintained in accordance with Federal confidentiality regulation (42 CFR, Part 2), which prohibits further disclosure without written consent of the person to whom it pertains or other permitted by 43 CFR, Part 2.

Your Rights with Respect to this Authorization:

Right to inspect or copy the health information to be used or disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contracting our Privacy Officer at (707-965-6339). **Right to receive copy of this authorization** – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to refuse to sign this authorization** – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to withdraw this authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact our Privacy Officer at (707-965-6339). I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date:

This authorization is good until the following date(s)____________________ from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative: ____________________ Date: ____________________
(If signed by other than patient, state relationship and authority to do so.)

Witness: ____________________

206335 04/2007