UNICARE COMMUNITY HEALTH CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By completing this document, you are authorizing the use/disclosure of Protected Health Information (PHI) in accordance with state and federal laws. Failure to provide all information requested may invalidate this authorization.

LAST NAME | FIRST NAME | DATE OF BIRTH

STREET ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER

TO RELEASE

I HEREBY AUTHORIZE THE FOLLOWING PROVIDER TO RELEASE MY PHI, AS DETAILED IN THIS DOCUMENT:

PROVIDER NAME

STREET ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER | FAX NUMBER

TO RECEIVE

I HEREBY AUTHORIZE THE FOLLOWING PROVIDER TO RECEIVE MY PHI, AS DETAILED IN THIS DOCUMENT:

PROVIDER NAME

STREET ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER | FAX NUMBER

INFORMATION TO BE RELEASED

☐ All health history pertaining to: medical history, dental history, physical condition and treatment received.
☐ Other (Please specify.): ____________

DATES OF RELEASE (If marked "other".)

FROM | TO

PURPOSE OF RELEASE

☐ Continuation of care at other healthcare provider
☐ Other (Please specify.): ____________

I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION: (SELECT AS APPLICABLE AND SIGN.)

☐ Substance abuse (including alcohol/drug abuse)
☐ Mental health (including psychotherapy notes)
☐ HIV related information (aids related testing)

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

X ____________

1. I understand that if I am authorizing the release of PHI from Unicare Community Health Center, I have the right to revoke this authorization at any time provided that my revocation is in writing.
2. I understand that information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
3. I understand that I have I have the right to receive a copy of this authorization.
4. I understand that this authorization will be invalid after sixty (60) days from the date noted below.

____________ LAST NAME | ____________ FIRST NAME

____________ SIGNATURE OF PATIENT/LEGAL GUARDIAN | ____________ DATE