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.

PATIENT INFORMATION

LAST NAME	FIRST NAME	DOB
STREET ADDRESS		CITY
STATE	ZIP CODE	PHONE NUMBER

TO RELEASE

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

PROVIDER NAME			
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER		

DATES OF RELEASE

FROM ____________________ TO ____________________

LIMITATIONS

All medical records selected above in the specified date range, **EXCEPT**: ____________________

INFORMATION TO BE RELEASED (Check all that apply.)

- ☐ Lab Results
- ☐ X-Ray Results
- ☐ Progress Notes
- ☐ Obstetrical Records
- ☐ Ultrasound Results
- ☐ Other (Please specify) ____________________

PURPOSE OF RELEASE

- ☐ Continuation of care
- ☐ Insurance
- ☐ Transfer of Care to New PCP
- ☐ Legal
- ☐ Personal Use
- ☐ Transfer of Care to New OB
- ☐ 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.

IF REQUESTED BY A PERSON OTHER THAN THE PATIENT, INDICATE RELATIONSHIP TO PATIENT BELOW.

☐ Parent of a minor	☐ Administrator of estate
☐ Guardian	☐ Executor of will
☐ Conservator	☐ Other (Please specify) ______________

NOTE: You must attach legal documentation to verify that you are the parent, conservator, guardian, executor of a decedent's will, or have medical decision-making authority for the individual.

____
PATIENT/LEGAL GUARDIAN NAME

______________________________ ______________
PATIENT/LEGAL GUARDIAN SIGNATURE DATE

INTERNAL USE ONLY

PAYMENT COLLECTED			RELEASE RECEIVED	PAGES
☐ Not Applicable ☐ Yes	If yes, when?	DATE		
RELEASED BY (Employee Information)				
FIRST NAME		LAST NAME		