COMMUNITY MEDICAL CENTERS

PATIENT INFORMATION

DATE: _____ PATIENT NAME/AKA _____ MED. REC.# _____

TELEPHONE: _____ SOCIAL SECURITY # _____ BIRTH DATE: _____

INFORMATION TO BE RELEASED FROM

I hereby authorize the release of all information in my medical record from

Name: _____

Address: _____

Including contents regarding drug/alcohol abuse, psychiatric, **psychotherapy notes and *HIV related (AIDS) diagnosis/test results. Exclusions: _____

INFORMATION TO BE RELEASED TO

Name of Organization / Person _____

Address _____ City _____ State _____ Zip _____

(*A separate authorization is required for each HIV disclosure and a **specific separate authorization requesting only psychotherapy notes is required.)

TYPE OF INFORMATION TO BE RELEASED

Dates of Treatment From _____ to _____

TYPE OF RECORD

- ☐ All Medical Records (pertinent only)
  (*Limited to 2 years of information)
- ☐ History & Physical
- ☐ Consultation
- ☐ Operative Report
- ☐ Discharge Summary _____
- ☐ Other Information (specify) _____
- ☐ Psychotherapy notes only
- ☐ Radiology Report (specify) _____
- ☐ Lab Results
- ☐ Evidentiary Examination
- ☐ ER Report

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Purpose or need for this information is: ☐ Medical ☐ Legal ☐ Insurance ☐ Personal ☐ Other

Health Information Management
Authorization for Release
of Protected Health Information

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Restrictions / Duration / Rights

- I authorize the release of the specified information from my medical records.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws (HIPAA). However, under California law the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law pursuant to state confidentiality laws.
- I revoke this authorization for Release of Protected Health Information as of _____ .
  Signature _____
- This authorization may be revoked at any time. My revocation will be effective upon receipt, but ill have no impact on uses or disclosures made while my authorization was valid.
- CMC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- This authorization expires six months after the date of signature, or as specified _____ .
- A photocopy of this release is as effective as the original.
- I have received a copy of this authorization.
- ☐ If this box is checked, Community Medical Centers will receive compensation for the use or disclosure of my health information.

SIGNATURE: _____ DATE: _____
Patient / Legal Representative / Guardian

If signed by other than patient, indicate relationship: _____

Witness: (Print Name) _____ Signature _____

Interpreter Signature If Applicable

I have accurately and completely read the foregoing document to

_____
Patient's / Legal Representative's Name

in _____ , the patient's or legal representative's primary language.
Language

(He/she) understood all of the terms and conditions and acknowledged (his/her) agreement thereto by signing the document in my presence.

Interpreter's Signature _____ Date: _____

FOR OFFICE USE ONLY

I.D. Checked ☐ Yes ☐ No Fee Explained ☐ Yes ☐ No
Amount Paid _____ Receipt # _____
☐ Mail ☐ Pick up Initials _____