SAN BENITO HEALTH FOUNDATION

COMMUNITY CENTER

351 Felice Drive, Hollister, CA 95023
Phone: (831) 637-5306 Fax: (831) 637-5842

Date:_____
SBHF MED REC#_____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT NAME:_____BIRTH DATE: _____

INFORMATION TO BE RELEASED FROM:

NAME / AGENCY: _____

ADDRESS: _____

PHONE: _____

FAX:_____

INFORMATION TO BE RELEASED TO:

NAME / AGENCY: _____

ADDRESS: _____

PHONE: _____

FAX: _____

PURPOSE AND LIMITATIONS FOR RELEASE: _____

□ Intake Assessment	□ Consultation Reports	□ Diagnoses (Medical)
□ Lab Reports	□ Physician's Orders	□ Discharge Summary
□ Treatment Plans	□ Progress Notes	□ Diagnoses (Psychiatric)
□ Psychiatric Evaluation	□ Psychological Test / Evaluation Results	
□ Outpatient records	□ Records relating to drug or alcohol abuse summary	
□ Complete hospital chart	□ Radiological images	□ HIV Test Results

Other (Specify):_____

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires one year from the signed date. I am aware and have been advised of the provisions of existing Federal **Health Insurance Portability and Accountability Act (HIPAA), Confidentiality of Medical Information Act (CMIA)** and other State Statutes, Rules and Regulations, **as outlined on page 2 of this form,** which provide for my right to confidentiality of the information in these records.

I realize that this authorization is required for release of my medical information and that I must voluntarily and knowingly sign this authorization before any records can be released, and that I may refuse to sign, and in that event the records cannot and will not be released.

Patient Initials_____

I further release my attending physician, the clinic/hospital and employees of the clinic/hospital, school and employee from any liability arising from the release of information to the person(s)/agency designated above. **A PHOTOCOPY / FAX OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.**

_____has the right to receive a true copy of this authorization by
(NAME OF PATIENT/GUARDIAN)

placing initials _____ to the left of this clause on the original authorization.
(HIS OR HER)

_____acknowledges that a true copy of this authorization and the
(NAME OF PATIENT/GUARDIAN, PLEASE PRINT)
Separate "Information For authorization" has been received.

_____ _____
SIGNATURE OF PATIENT **DATE**

_____ _____
SIGNATURE OF PARENT/ GUARDIAN / REP (when applicable) **DATE**

RELATIONSHIP TO PATIENT: _____

INFORMATION OF AUTORIZATION

The privacy and confidentiality of patient medical records information is protected by Federal and State Statutes, Rules and Regulations (including: Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information – 45 CFR Parts 160 through 164, California Confidentiality of Medical Information Act; California Administrative Code, Title 22; California Civil Code section 56 et seq. California Welfare and Institutions Code, section 5328; and Title 42 of the Code of Federal Regulations). These Statutes, Rules and Regulations require that the client give informed consent prior to the release of any health / hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations.

California Civil Code section 56.11: An authorization to release health /hospital information will be considered valid only when it states: (1) who will release the information; (2) who will receive the information; (3) the purpose and limitations for which the information will be used; (4) what specific information will be released; and (5) when the authorization will expire. The authorization must also contain the client's/authorized representative's signature and the date of the signature. This Authorization of the Release of Protected Health Information waives any and all rights that the patient now has or may in the future have to bring any legal action against the releasing person / facility for any damages caused directly or indirectly by the release of this information or other confidential information. The authorization must be completely filled out and cannot be missing any required elements.

A minor client may only sign an authorization for the release of their health /hospital information for services which the minor consented or could have lawfully consented. The authorization of their parent or authorized representative is needed for the release of their health /hospital information for services which the minor could not lawfully consent. The signature of the authorized representative is required for patients who are conservatives under the Probate Code and those adults lacking capacity to consent. Authorized representative signing for the client must submit copies of the legal documents supporting the assignment of this authority.

Upon request, you will be furnished with a copy of the completed "Authorization for the Release of Protected Health Information" and "Notice of Health and /or Mental Health Information Practices".

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.