CommuniCare HEALTH CENTERS

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION (PC AND PN ROI)

Place Patient Label Here

☐ **Davis Community Clinic**
2051 John Jones Road
Davis, CA 95616
Fax: 530-758-8490

☐ **Hansen Family Health Center**
215 West Beamer Street
Woodland, CA 95695
Fax: 530-204-5295

☐ **Salud Clinic**
500 B Jefferson Blvd #180
West Sacramento, CA 95605
Fax: 530-204-5248

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email (optional): _____

I HEREBY AUTHORIZE COMMUNICARE HEALTH CENTERS TO:

☐ **RELEASE to:**
OR
☐ **REQUEST from:**

☐ Check this box if same as patient listed above.
Name of Person or Organization: _____
Address: _____ City: _____
Zip: _____ Phone: _____ Fax: _____

PURPOSE OF REQUESTED USE OF DISCLOSURE

☐ Continuity of Care—Appointment Date with Physician: _____
☐ Patient ☐ Insurance ☐ Other: _____

TYPE OF RELEASE (select **one**)

☐ Paper Copy ☐ CD ☐ Verbal Exchange (***no copies***)
☐ Email – encrypted ☐ Email – non-encrypted*

Delivery Method (Select **ONE**)
☐ Mail ☐ Fax ☐ Pick-Up (if applicable)
☐ Email: _____

* Sending **non-encrypted** email increases the risk that information could be read by an unauthorized party.

INFORMATION REQUEST

CommuniCare Health Centers makes reasonable efforts to limit disclosure of Protected Health Information to the **minimum amount of information necessary** to accomplish the intended purpose.

Current or Most Recent

SCREENING
☐ Pap smear ☐ Newborn Screen
☐ Colonoscopies ☐ Other: _____

ALL ADVANCED DIAGNOSTIC IMAGING
☐ CXR ☐ Mammography ☐ Other: _____

MEDICAL LISTS
☐ Problem List ☐ Medication List
☐ Immunizations

☐ **OTHER**: _____

Last 12 Months

☐ Consultation Notes
☐ Other: _____

Prenatal/Women's Health

☐ Pap smear records – **Date:** _____
☐ C-section records – **Date:** _____
☐ Prenatal Records – **Date:** _____
☐ Other: _____

Other Records

☐ **LAST THREE (3) PROGRESS NOTES** with associated Lab/Pathology Results
☐ Hospital Records – **Date:** _____ ☐ Other: _____
☐ Discharge Summaries: **Date:** _____ **Date:** _____

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NOTE: Your health record may include information that references HIV/AIDS, alcohol/drug or behavioral/mental health services. The actual treatment records from HIV/AIDS, alcohol/drug, and/or behavioral/mental health will not be disclosed unless specifically requested below.

SPECIAL AUTHORIZATION *(Tell us if we have permission to release the following sensitive information)*

☐ HIV test results dated from _____ to _____ Sign: _____ Date: _____

☐ Substance abuse dated from _____ to _____ Sign: _____ Date: _____

☐ Behavioral Health dated from _____ to _____ Sign: _____ Date: _____

EXPIRATION

This authorization shall become effective immediately and shall remain in effect for one (1) year from the date signed unless a different date is specified here: _____

RESTRICTIONS

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

YOUR RIGHTS

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address:

  CommuniCare Health Centers
  PO Box 1260
  Davis, CA 95617
- My revocation will be effective upon receipt but will have no impact on uses or disclosure made while my authorization was valid.
- I have a right to receive a copy of this authorization
- I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure of my health information.

SIGNATURE

Signature: _____ Date: _____ Time: _____
(Patient or Legal Representative)

If signed by other than the patient, print name and relationship:

Name: _____ Relationship: _____