CHI HEALTH CARE

Authorization for Disclosure and Release of Medical and Mental Health Information

Name: _____ D.O.B.: _____ Phone: _____
Address: _____ City:_____ State: _____ Zip code: _____

I hereby authorize, the release of my medical or mental health information from/to the following parties:

FROM: Name of person or facility: _____
Address: _____
Phone: _____ Fax:_____

TO: Name of person or facility: _____
Address: _____
Phone: _____ Fax:_____
*Email Address: _____

Type of disclosure: ☐ Verbal ☐ Copies of record

The purpose of this disclosure is for:

☐ Ongoing treatment ☐ Employment ☐ School ☐ Legal ☐ Personal use ☐ Other

Delivery Method: ***Charges may apply for methods other than encrypted email*** *(Note: Most records are available to you free On Demand in CCDA digital download or PDF print-out format at any time through our Patient Portal, see front desk for instructions)*

CCDA File (.xml digital file readable by software) ⟶ ☐ Encrypted Email ☐ USB thumb drive ☐ Patient Portal

PDF File (Human readable) ⟶ ☐ Encrypted Email ☐ Paper Print-out ☐ USB thumb drive ☐ Patient Portal

By <u>INITIALING</u> below, I am authorizing the release and/or receipt of the following information:

_____ All medical services information
_____ All mental health counseling information (*Subject to MD's Confidentiality of Medical Records Act, codified at Health-General 4-301 et seq)*

Complete medical record	_____ All	**OR**	_____ From _____	to _____
Consult reports	_____ All	**OR**	_____ From _____	to _____
Labs results	_____ All	**OR**	_____ From _____	to _____
Radiology reports	_____ All	**OR**	_____ From _____	to _____
Vaccine records	_____ All			

Please indicate type(s) of Information, if not specified above (e.g. Summary Report, Attendance Verification):

_____

All information regarding Alcohol and/or Drug Abuse (42 C.F.R. 2.34 and 2.35) or HIV/AIDS [Health and Safety Codes 120980(g)] will be released **unless you restrict it by <u>INITIALING</u> here:** _____

Limitations, if any, upon disclosure: _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.
- I understand that I may revoke this authorization at any time and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that if I have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality law.
- I understand that a photocopy or fax of this form is the same as the original.
- I understand that Casey Health Institute will not release any records from a third party (i.e. hospital records) unless I authorize CHI Health Care to do so.

_____ _____
Signature Date