



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.

Form fields for patient information: LAST NAME, FIRST NAME, DATE OF BIRTH, STREET ADDRESS, CITY, STATE, ZIP CODE, PHONE NUMBER.

Authorization sections: TO RELEASE (I HEREBY AUTHORIZE THE FOLLOWING PROVIDER TO RELEASE MY PHI...) and TO RECEIVE (I HEREBY AUTHORIZE THE FOLLOWING PROVIDER TO RECEIVE MY PHI...). Includes fields for provider name, address, city, state, zip code, phone number, and fax number.

INFORMATION TO BE RELEASED section with checkboxes for 'All health history pertaining to: medical history, dental history, physical condition and treatment received.' and 'Other (Please specify.):'. Includes a field for 'DATES OF RELEASE (If marked "other".)' with 'FROM' and 'TO' sub-fields.

PURPOSE OF RELEASE section with checkboxes for 'Continuation of care at other healthcare provider' and 'Other (Please specify.):'.

I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION: (SELECT AS APPLICABLE AND SIGN.) section with checkboxes for 'Substance abuse (including alcohol/drug abuse)', 'Mental health (including psychotherapy notes)', and 'HIV related information (aids related testing)'. Includes a signature line for 'SIGNATURE OF PATIENT OR LEGAL GUARDIAN' with an 'X' mark.

- 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.

Signature and date fields: LAST NAME, FIRST NAME, SIGNATURE OF PATIENT/LEGAL GUARDIAN, DATE.