3184 Churn Creek Road
Redding, CA 96002
530-768-2436
FAX: 530-722-4151
FAX: 530-221-1327

Email: CCHCMedicalRecords@churncreekhealthcare.com

AUTHORIZATION TO RELEASE INFORMATION

This authorization is not valid if it has not been filled out completely. Please fill in all red items.

Patient's name:____________________________ Chart #: ________________

Address:__________________________________ Date of birth: __________

____ Phone #: ____________

Description of and/or limitation on information to be disclosed:

- ❑ Immunization Records
- ❑ Current History & Physical
- ❑ Current Medication/Problem List
- ❑ Progress Notes
- ❑ Lab Results
- ❑ X-Ray/Imaging/Diagnostic Reports
- □ Dental
- ❑ Mental Health Progress Notes (Initials____)
- ❑ Alcohol or Drug Treatment/Referrals (Initials_____)
- ❑ HIV/AIDs related Tx (Initials____)
- ❑ Sexually Transmitted Diseases (Initials____)
- ❑ Psychiatric Notes (Initials_____)
- ❑ Other ________________________

Time Frame: *Choose one date range option*

□ Past 6 Months □ Past 2 Years □ Dates:___/__/___to___/__/___

Disclosure of information **from:**
(name, phone/fax & address)

____

____

____

Disclosure of information **to:**
(name & complete mailing address)

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Purpose of disclosure/specific use of information:

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I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to cancel this authorization at any time. I understand that if I cancel this authorization, I must do so in writing and present my written cancellation to the Medical Records Department. I understand that it will not apply to information that has already been released in response to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise cancelled, the disclosure of medical information is valid one year from date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have copied the information to be used or disclosure, as provided in CFR 164.524. I understand that the information disclosed may be re-disclosed and that the re-disclosed may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the Medical Records staff @ 530-768-2436.

I understand that I have right to receive a copy of this authorization form.

I understand that there may be a fee charged for processing this request.

______________________________ ______________________________
(**Signature** of Patient/Legal Representative) (**Printed name** of person signing form)

____
(If signed by Legal Representative: relationship to patient or description of authority to act)

______________________________ ______________________________
(Signature of Witness, if applicable) (Date signed)

This form complies with requirements of 45CFR164.508(c) & CA Civil code 56.11