Sea Mar
Community Health Centers
Clínica de la Comunidad

Authorization to Use or Disclose Protected Health Information
Health Information Management Department
Location/Department: ______________________

PATIENT MRN:

Method of disclosure: ☐ In-Clinic ☐ Verbal ☐ CD ☐ Paper ☐ Fax (please mail if over 40 pages)

PATIENT INFORMATION	Name: ______________________ DOB: __________ Address: ______________________ City: ______________ State: __________ Zip: ________ Primary Phone: ______________ E-mail: ______________ Sea Mar Primary Care Provider: ______________
From *Please list the specific hospital, provider or clinic disclosing records*	Name: ______________________ Address: ______________________ City: ______________ State: __________ Zip: ________ Phone: ______________ Fax: ______________
To *Please list who will receive records*	Name: ______________________ Address: ______________________ City: ______________ State: __________ Zip: ________ Phone: ______________ Fax: ______________
Information to be released *Please <u>initial one</u> section*	___ Recent summary of care including Medication List, Problem List, Last three H&P/Progress Notes, Recent Imaging, Immunizations, Last Pap Smear, Last Mammogram, Last Colonoscopy, EKG, Recent lab work, MH Intake, SUD Assessment ___ All records (excludes Sensitive Patient Information listed below) ___Lab Results (Specify dates or tests): ______________ ___ Mental Health Records (Specify dates or diagnosis): ______________ ___ Dental Records & Dental X-Rays only ___The most recent two years of records ___ Other: ______________
Sensitive Information ***Unless initialed these records will not be sent***	**<u>Title 42 of the United States code, stipulates this information cannot be released without Authorization by law.</u>** Please initial to authorize the following information to be released: _____ HIV/AIDS _____Sexually Transmitted Diseases _____ Substance Abuse _____Mental Health/Psychiatry Conditions
Consent of Minors for Sensitive Information	Minors ages 13 to 17 must provide authorization to release the sensitive information below: ***<u>Please initial applicable sections and sign</u>*** ______ Contraception, pregnancy and pregnancy termination, sterilization (age 14 and older) ______Conditions related to HIV/AIDS/Sexually transmitted diseases (ages 14 and older) ______Alcohol and/or drug abuse (age 13 and older) ______Mental health/psychiatry conditions (age 13 and older) Minor's signature: ______________________ Date: ______________
Purpose of the release	☐ At my request ☐Transfer of Care ☐ Verbal Disclosure ☐Other (Specify Reason):______________________
Expiration	**This authorization expires 90 days from the date signed unless specified below.** ☐ When revoked in writing ☐ One year from the date of signature ☐ When Records Received ☐ The following date/event: ______________
Patient Rights	I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). I understand I have to sign this authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party. I understand I may revoke this authorization in writing at any time. If I do so, this will not affect any actions already taken by the disclosing health care entity in accordance with the authorization. I understand that once health care information is disclosed, if the person or organization that receives it is not covered by federal or state patient privacy laws, the health care information may be re-disclosed without protection of privacy laws.
Signature	I have read this authorization, and I understand it. ______________________ ______________ Signature of patient or legal representative Date ______________________ ______________ Printed name is signed by party other than patient Relation to patient if not self

Staff Use Only - Please print name

□ Verified all sections are complete: ______________ □ **I have completed all actions. Scan this form to the patient's chart (staff initials): ________**