Community First Health Centers

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: ____
(First) (Middle) (Last) (Previous Name)

Address: ____
(Street Address) (City) (State) (Zip Code)

Date of Birth: __________________ Home Phone: _________________________ Work Phone: ________________________

Social Security Number: ______________________ My Provider Community First Health Centers is ___________________________

Reason for record request:

____

Release records **from** Community First Health Centers **to**:	Release records **to** Community First Health Centers **from**:
Name	Name
Address	Address
City State Zip Code	City State Zip Code
Phone Fax	Phone Fax

IMPORTANT – You may disclose health care information regarding testing, diagnosis, and treatment for (check yes or no):	Information to be released (be specific):
○ Yes ○ No HIV (AIDS Virus)	○ Last 2 years of records
○ Yes ○ No Sexually Transmitted Diseases	○ Last 5 years of records
○ Yes ○ No Psychiatric Disorders/Mental Health	○ X-Ray/Lab Results (Specify Dates) Dates: ______________________
○ Yes ○ No Drug and/or Alcohol Use	○ Only Dates of Service (Specify Dates) Dates: ____________ to ____________
○ Yes ○ No Medication(s)	○ Other Records or Information (Please Specify):
○ Yes ○ No Medical Information	______________________________

This authorization expires within one calendar year of being signed. If you wish to have the authorization expire before one calendar year, please indicate the date of expiration:

____

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an 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 may revoke this authorization in writing by sending such written revocation to Community First Health Centers at the above address. If I did, it would not affect any actions already taken by Community First Health Centers based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may inspect or copy (at additional expense) the information to be used or disclosed, as provided in CFR 164.524. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

____ ________________ ______________
Patient or legally authorized individual signature Date Time

______________________________________ ________________________________
Printed name if signed on behalf of the patient (Parent or Legal Representative) Relationship

______________________________________ ________________________________
Witness Signature Date

Office Use Only
Date received: ______________
Provider Initials: ______________
Date released: ______________
Staff initials who sent info: ______

This institution is an equal opportunity provider.
Partially funded by a Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services Grant
Accredited by The Joint Commission on Accreditation of Healthcare Organizations
NCQA Recognition for Patient Centered Medical Home