Community First Health Centers
Improving the quality of life for our community.

OFFICE USE ONLY

Date received: _____ **Provider initials:** _____

Date released: _____ **Initials of staff who sent info:** _____

Authorization to Disclose/Release Protected Designated Health Record Set Information

Please complete this form in its entirety so we can help you receive the information you are requesting.

1. **This authorization is voluntary. I understand that Community First Health Centers will not base treatment, payment, enrollment, or eligibility for benefits on my signing this document**.

Patient full name: _____ Maiden/AKA: _____ Date of birth: _____

Street address: _____

City/State/Zip: _____ Telephone #: _____

Email address: _____

2. ☐ **Myself:** I request Community First Health Centers to release my protected health information to Myself.
Select delivery method: ☐ **Email** ☐ **Pick up in office** ☐ **US Mail** (to address listed above) ☐ **Fax:** _____
3. ☐ **Other:** I am the patient or the legally-authorized representative of the patient listed above and I request Community First Health Centers to release my protected health information (or the protected health information of the patient named above) to:

Individual/person: _____ Company/organization: _____

Street address: _____

City/State/Zip: _____ Telephone #: _____

Fax #: _____

Select delivery method: ☐ **Fax** ☐ **US Mail** ☐ **E-mail:** _____

4. **Purpose of release/disclosure to another person/organization:**

☐ Continuation/transfer of care ☐ Worker's compensation
☐ Attorney/legal ☐ Patient directive
☐ Insurance company ☐ Other (specify): _____

5. **Records to be released:**

I hereby authorize Community First Health Centers to release/receive any and all medical records and information as specified below, relating to my care and treatment which may include x-rays, photographs, electronic and digital files and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records, if any, relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2; psychiatric/psychological services and social work records, and any information regarding communicable diseases and infections, defined by Michigan Department of Public Health rule, which can include tuberculosis, venereal diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or AIDS-Related Complex (ARC). This does not include psychotherapy notes.

Information to be released (be specific):

☐ Transfer of x-ray results records (unless told otherwise, this is typically all another dental clinic would like sent) [specify date(s)]: _____

☐ Clinical Chart Notes [specify date(s)]: _____

☐ Perio Chart [specify date(s)]: _____

☐ The Designated Record Set (this is the entire dental record, including billing information): _____

Check below for any **EXCLUSION**:

☐ Alcohol/Substance Abuse ☐ Mental Health Records ☐ HIV/AIDS

☐ Other (specify): _____

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6. Release of records TO Community First Health Centers:

OFFICE USE ONLY
Send medical records via:
☐ US Mail ☐ Fax ☐ Email

☐ I authorize release of records to **Community First Health Centers**
ATTN: Dental Department
1011 Military Street
Port Huron, MI 48060
Fax # 810-488-8003 from: _____

☐ I authorize release of records to **Community First Health Centers**
ATTN: Dental Department
58144 Gratiot Avenue, PO Box 480430
New Haven, MI 48048
FROM: **Fax # 586-749-5381 from:** _____

Name: _____

Street Address: _____ City/State/Zip: _____

Telephone #: _____ Fax #: _____

7. I may revoke this authorization in writing by sending a written notice to the Community First Health Centers location where I received services, addressed to the attention of Medical Records. A request to revoke an authorization 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. **This authorization expires upon my revocation of this consent or within one calendar year of being signed. If you wish to have this authorization expire before one calendar year, please indicate the date of expiration here**: _____.

8. To protect your health record information, any information requested to be sent by email will be encrypted and password protected unless it is requested otherwise. Communications sent by email over the Internet are not always secure and may be intercepted and read/received by someone other than who it was addressed to. Choosing to have the requested health information by email implies that you accept this risk.

_____	_____	_____	_____
Patient or legally-authorized individual signature	**Print name**	**Date**	**Time**
_____	_____	☐ Translation provided	
Witness signature	**Date**		

The Standards for Privacy of Personally Identifiable Health Information, 45 CFR Parts 160 and 164, states that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of this information. The federal confidentiality Rules CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure if this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 1. 11/14/2018

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

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