COMMUNITY
MEDICAL CENTERS

Medical Record#:_____

Patient Name:_____ Phone: _____

Address (Street, City/State, Zip): _____

Date of Birth: _____ SSN (last 4 digits): _____

1. **I hereby authorize that my protected health information be released from:**
   Healthcare Facility Name: _____
   Address (Street, City/State, Zip):_____
2. **Information to be released to:**
   Name of Organization/Person: _____
   Address (Street, City/State, Zip):_____
3. **Purpose for requesting information:**
   ☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal ☐ Other:_____
4. **Method of release:**
   ☐ Mail to address ☐ Pick-up ☐ MyChart/Other (electronic portal) ☐ Other: _____
5. **Requested format:**
   ☐ Paper ☐ CD (for electronic patient records if available) ☐ MyChart/Other (electronic portal)
6. **Applicable fees:** An invoice will be sent to you prior to release of records for any applicable copying fees (cash or money order only). Applicable fees must be received prior to release of records.
7. **Type of information to be released:** I understand that this authorization includes the release of **all** medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, **including psychological or psychiatric impairment, drug abuse and/or alcoholism, or Acquired Immunodeficiency Syndrome (AIDS); or tests for Infection with Human Immunodeficiency Virus (HIV).**
8. **Covering the period of healthcare from:** Specific Date(s):_____ to _____
9. **Type of information to be released from my medical record(s):**
   ☐ a) Complete Medical Record (all pages)
   or
   ☐ b) Pertinent Medical Record (includes Dictated Physician Reports/Test Results)
   or
   ☐ c) Only the following type(s) of information: **(please check)**

☐ History & Physical	☐ Operative Report	☐ EKG's	☐ Immunization Records
☐ Consultation Report	☐ Pathology Report	☐ Radiology	
☐ Discharge Summary	☐ Lab Results	☐ Emergency Room Record	☐ Billing Records

Other Medical Documents (Please Specify): _____

_____

10. **Please specify below any exclusions or limitations to the medical records being released:**

_____

Health Information Management
Authorization to Release Protected Health Information
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FOR OFFICE USE ONLY

ID Checked ☐ Yes ☐ No ___ Fee Explained ☐ Yes ☐ No
Amount Paid _____ Receipt # _____
☐ Mail ☐ Pick up Initials_____

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11. **Expiration:** This authorization shall become effective immediately and shall remain in effect until: _____. If no date is given, the authorization will be valid for six (6) months from the date of signing.

12. **Restrictions:**
California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law.The protection does not extend to recipients outside the state of California.

13. **Rights / Duration:**
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws Health Insurance Portability and Accountability Act (HIPAA).
- This authorization may be revoked at any time. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made by me while my authorization was valid.
- I revoke this authorization for Release of Protected Health Information as of _____
Signature _____
- Community Medical Centers may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- A photocopy of this release is as effective as the original.
- I have received a copy of this authorization.
- ☐ If this box is checked, Community Medical Centers will receive compensation for the use or disclosure of my health information.

14. **Signature:**

_____
Signature: (Patient/Representative/Guardian) Date: Time:

_____
If signed by other than patient, print name and indicate relationship to patient.

Authorized representative signing for the patient must also submit copies of the legal documents describing the personal representative's assignment of this authority.

_____ Date: _____ Time:_____
Witness Signature # 1 / Print Name / Title

_____ Date: _____ Time:_____
Witness Signature # 2 / Print Name / Title
(Witness Signature #2 required if patient marks with an "X".)

15. **Interpreter Signature If Applicable:**
I have accurately and completely read the foregoing document to:

_____
Patient / Legal Representative Name

In _____, the patient's or legal representative's primary language.

He/she understood all of the terms and conditions and acknowledged his/her agreement thereto by signing the document in my presence.

_____ Date: _____ Time:_____
Interpreter Signature / Print Name / Title