LA CLINICA
AFFORDABLE HEALTH CARE EXCELLENCE FOR ALL

PCP:
OR
PCD:

AUTHORIZATION TO RELEASE INFORMATION

Patient Full Name _____ **Date of Birth** (MM/DD/YYYY) _____ **Electronic Health Record Number** _____

1 I authorize the release of my health information from: (***Who*** has the information you want released? Please list the specific hospital or clinic.)

Place Site Location Stamp Here

Name
Address
City
State
Zip
Phone/Fax

2 I authorize the release of my health information to the following person(s) or organization: (***Where*** do you want the information sent or ***who*** may have the information?)

Place Site Location Stamp Here

Name
Address
City
State
Zip
Phone/Fax

3 For the following purpose(s): □ Continuity of Care □ Copies for Own Use □ Insurance □ Legal
□ Transfer Care □ Other (specify) _____

4 Information Requested:

□ Itemized Billing Records □ Laboratory Reports □ Counseling/Mental Health Support
□ Complete Medical Record – Past Two Years □ Imaging Report(s) □ Medication Records
□ Complete Dental Records □ Immunizations □ Other: _____
(Including radiographs)- Past two years
□ Dates of Care to be Released: _____ to _____

5 Select format: □ MyChart □ Mail □ Pick up-location _____ □ Fax _____
□ Protected email. ***Note***: Opening protected email requires a registration process when you get the first email.
□ Unprotected email. ***Initials: _____I understand that not encrypting email increases the risk that information could be accessed by a third party while in transit.***

*****Sensitive information listed below will not be shared unless initialed*****

6 I UNDERSTAND THAT if the requested information includes any of the sensitive information listed below, additional federal or state laws may apply. By **initialing** next to each section, **I give my permission for the information to be shared.**

Initials: _____ Drug Use Diagnosis/Treatment
Initials: _____ Alcohol Use Diagnosis/Treatment
Initials: _____ Sexually Transmitted Disease
Initials: _____ HIV/AIDS Test Results
Initials: _____ Genetic Testing Results
Initials: _____ Sickle Cell Anemia
Initials: _____Mental Health Diagnosis/Treatment

I UNDERSTAND THAT:

The information used or shared by this authorization may be re-shared with others and no longer be protected under the federal law. However, I also understand that federal or state law may limit re-disclosure of some of the sensitive information described on page 1. (45 CFR§164.508 (c)(2)(iii))

I am not required to sign this authorization. Choosing not to sign will not affect me from receiving health care or reimbursement for services. The only time when refusing to sign it may stop me from getting the health services needed is if the services are done only to provide health information to someone else and authorization is needed to send them the information. (45 CFR§164.508 (c)(2)(ii))

I have a right to request, in writing, a list of who has received my health information for reason other than treatment, payment, health care operations or disclosures specifically authorized by me. I am aware I can receive a copy of a list of any 12-month period and it will be provided at no cost.

I may cancel this authorization at any time by submitting a written request or by completing the La Clinica Revocation of Authorization form.

If I cancel this authorization, I understand that this does not affect previously information shared. I may not be able to withdraw my authorization if it was done to obtain insurance coverage. (45 CFR§164.508 (c)(2)(ii))

In La Clinica's school-based health centers, protected information will be used or shared only when necessary to help a purpose that is related to the health and protection of a child's wellbeing and ability to learn and succeed.

This authorization shall expire one (1) year after the date signed **unless a different** expiration date is written here:

Expiration date: _____

(MM/DD/YYYY)

_____ _____

Signature of Patient or Legal Representative/Guardian | Date:

_____ _____

Printed Name of Patient/Legal Representative/Guardian | Relationship of Legal Representative or Guardian

_____ _____

Witness Signature *(when signed in office)* | Printed Name of Witness

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Staff Use Only*:*

□ Health Records requested by _____ *(Enter La Clinica care team member name requesting records)*

For Staff Processing ROI Use Only:

□ Patient picked up □ Faxed □ Mailed □ Other _____

□ Health Records sent to _____for patient to pick up

Staff Name: _____ Date: _____