LA CLINICA
AFFORDABLE HEALTH CARE EXCELLENCE FOR ALL

AUTHORIZATION TO RELEASE INFORMATION

PCP:
OR
PCD:

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

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

5. 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 Abuse Diagnosis/Treatment
Initials: _____ Alcoholism Diagnosis/Treatment
Initials: _____ Sexually Transmitted Disease
Initials: _____ HIV/AIDS Test Results
Initials: _____ Genetic Testing Results
Initials: _____ Sickle Cell Anemia
Initials: _____Mental Health Records

I UNDERSTAND THAT:

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

I am not required to sign this authorization. Choosing not to sign will not stop me from getting health care or reimbursement for services. The only time when refusing to sign it may stop me from getting health services 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 reasons other than treatment, payment, health care operations, or disclosures I authorized. I know I can get a copy of this list once every 12 months at no cost.

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

If I cancel this authorization, I understand this does not affect information previously shared. I may not be able to withdraw my authorization if it was done to get 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 needed. The purpose must be related to the child's health, well-being, and ability to learn and succeed.

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

Date: _____
(MM/DD/YYYY)

_____	_____
Signature of Patient or Legal Representative/Guardian	Date **(MM/DD/YYYY)**
_____	_____
Printed Name of Patient/Legal Representative/Guardian	Relationship of Legal Representative or Guardian
_____	_____
Witness Signature *(when signed in office)*	Printed Name of Witness

---

***Staff Use Only**:*

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

□ If releasing records to patient, please select format: □ MyChart □ Mail □ Pick-up location_____ □ Fax

□ E-mail (Available only to and from **dental** provider offices)

For Staff processing ROI Use Only:

□ Patient picked up □ Faxed □ Mailed □ Other _____

□ Health records sent to _____for patient to pick up

Staff Name: _____ Date: _____