West County Health Centers

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE COMPLETE ALL SECTIONS, DATE, AND SIGN.

I. I, _____, Date of Birth_____, hereby voluntarily authorize the disclosure of
(Printed Name of Patient)
information from my health record.

II. RELEASE: ☐ FROM ☐ TO		**RELEASE: ☐ FROM ☐ TO**	
NAME OF HEALTH CENTER **West County Health Centers, Attn: Medical Records**		NAME OF PERSON/ORGANIZATION/FACILITY	
ADDRESS **652 Petaluma Ave; Suite H**		ADDRESS	
CITY/STATE **Sebastopol, CA 95472**		CITY/STATE	
Telephone **(707) 824- 8216**	**Fax** **(707) 824-9335**	Telephone	Fax

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research

☐ Personal Use ☐ Insurance ☐ Disability ☐ Other *(specify)* : _____

IV. (a) The information to be disclosed from my health record: (initial all appropriate line(s))

_____ Only information related to *(specify)* :_____

_____ Only for dates from _____ to _____

Unless otherwise indicated, only records 2 years prior to this request will be released

_____ Other (specify) (Dental, Lab, Billing, Teen Clinic, etc.): _____

_____ Entire Record* *(does not include Sensitive Protected Health Information unless specified below)*

(b) Sensitive Protected Health Information I request to be disclosed, initial the applicable line(s) below:

_____ Alcohol/Drug Treatment/Referral _____ HIV/AIDS-Related Treatment

_____ Mental Health Notes ONLY (by initialing, I am waiving any psychotherapist-patient privilege)

**** Initials Only (checks and X marks will not be accepted)***

V.

I understand that I may revoke this authorization in writing submitted at any time to: West County Health Centers, Medical Records Department, 6800 Palm Ave., Sebastopol, CA 95472, except to the extent that action has been taken in reliance on this authorization. Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure might not be protected by California law or federal HIPAA law, depending on the circumstances. Confidentiality of Medical Information Act (CMIA) prohibits such re-disclosure without a new written authorization except as specifically permitted or required by law (California Civil Code Subsection 56.13). If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____
(Specify new date)

West County Health Centers, its facilities, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized here in.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient)	DATE
SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark)	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

To note: The timeframe for Processing of Medical Record Release may take up to 30-days from signature date.