BAY AREA COMMUNITY HEALTH

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

If Requester is Patient (Check this Box): ☐

Name of Requestor: _____

Relationship to patient: _____

I hereby authorize Bay Area Community Health to (check one box):

☐ **RELEASE TO** **OR** ☐ **OBTAIN FROM**

Name of Physician/Health Care Facility/Provider/Patient: _____

Address: _____

Phone No.: _____ Fax No.: _____

Specify the Health Record to include:

☐ Health Records, Dated from _____ to _____

☐ Lab results, dated from _____ to _____

☐ Imaging Reports ☐ Immunizations

☐ OTHER (Specify): _____

With the following restrictions (list in detail): _____

NOTE: Health Record may include information related to mental health, alcohol/drug and HIV references. The actual treatment records from mental health and/or results of HIV tests will not be disclosed unless specifically requested below.

☐ Behavioral/Mental Health Information (patient initials _____)

☐ Results of HIV Blood Test (patient initials _____)

☐ Alcohol/Drug Abuse (patient initials _____)

This information may be used for:

☐ Patient Care ☐ Insurance or legal claim ☐ Personal

Media Type (check one):

☐ CD ☐ Paper

Delivery Preference (check one):

☐ Mail ☐ Fax ☐ Pick up

This authorization will automatically expire one (1) year from the date signed or on date: _____
(Unless revoked earlier in writing). I understand that I have a right to receive a copy of this Authorization.

I Understand that by signing this authorization:-

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.

HEALTH INFORMATION MANAGEMENT DEPARTMENT
40910 Fremont Blvd, Fremont, CA 94538 Ph: 510 252 5848 Fax: 510 770 8141

BAY AREA COMMUNITY HEALTH

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the Health Information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

_____ _____

Patient/Representative Signature Date

_____ _____

Provider Signature* Date

For Patient Pick Up Only:-

IDENTIFYING INFORMATION	
COPY OF IDENTIFICATION ATTACHED:-	
TYPE	(CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFITS IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD, GREEN CARD)
NUMBER	

*For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further the LPS act often requires that both patient's treating physician/provider and the patient must sign the authorization form before information is released.

FOR STAFF USE ONLY:

Information collected by (BACH staff name):_____ Clinic Site:_____

Information has been given to patient on: _____ by:_____
Date Print name

Information has been mailed to patient on: _____ by:_____
Date Print name

Information has been faxed to patient on: _____ by: _____
Date Print name

Information has been faxed to 3rd. party on: _____ by: _____
Date Print name

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