Comprehensive Community Health Centers

Authorization for Release of and/or to Obtain Information &
Individual Request for Access to Personal Health Information

Patient Name: ______________________________

DOB: ____________ Pt. ID ______________

From: ______________________	To: ______________________
Address: ______________________	Address: ______________________
City, State, Zip: ______________________	City, State, Zip: ______________________
Phone number: ______________________	Phone number: ______________________
Fax number: ______________________	Fax number: ______________________

- **Release of the following information from the above patient's health information (Please check):**
  - ☐ Progress notes
  - ☐ Billing records
  - ☐ Labs
  - ☐ Other: ______________________
  - ☐ Imaging reports (X-ray, CT, etc.)
  - ☐ Consult reports/Hosp. notes (Other facilities records)
- **Authorization for release of sensitive or statutory protected information from health information**

By initial next to any of the specific sensitive protected health information, you give authorization to release of this protected health information
__________**Psychotherapy Notes** __________Mental Health Record
__________HIV/AIDS
__________Substance Abuse (Alcohol, drug, etc.)

Dates of care from: ____________ to: ____________

This disclosure is being made for the following purpose(s):

☐ New primary care provider ☐ Specialist provider request ☐ Attorney/Court Case
☐ Insurance ☐ Personal Reasons
☐ Other: ______________________________

Delivery method (Check one):

☐ Fax: ____________________
☐ Paper Copy (will be processed within 7 business days) ☐ Mail ☐ Pick-up at clinic
☐ E-copy (will be processed within 3 business days) E-mail address: ____________________

Due to implementation of Electronic Health Records, only scanned and uploaded copies of original documents are available to be released. This authorization for disclosure of information is effective for one year from the date signed. This informed consent is subject to revocation at any time by written notification only, which can be submitted at info@cchccenters.org.

Patient OR Legal Representative Signature ____________________ Date ____________

OFFICE USE ONLY

The fee of $____________ is collected

- ☐ *Cash*
- ☐ *Credit/Debit*
- ☐ *Check*

Staff's name ____________________

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FEE SCHEDULE

For Release of and/or Obtain Information &
Individual Request for Access to Personal Health Information

Reason of request

- New primary care provider or healthcare facility – at no cost
- Records for one visit – at no cost
- Records for up to three visits - $3
- Records for up to six visits - $6
- Records for over six visits - $12
- Requests received from copying services or attorney office - $15