



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
- Labs
- Imaging reports (X-ray, CT, etc.)
- Consult reports/Hosp. notes (Other facilities records)
- Billing records
- Other: _____

➤ **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
- Insurance
- Other: _____
- Specialist provider request
- Personal Reasons
- Attorney/Court Case

Delivery method (Check one):

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

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.

Patient OR Legal Representative Signature

Date

OFFICE USE ONLY

The fee of \$ _____ is collected

- Cash
- Credit/Debit
- Check

Staff's name _____



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