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