AUTHORIZATION TO OBTAIN INFORMATION:

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION (Note: Fees may apply for certain requests)

Petaluma Health Center

Patient Name					
Date of Birth		Phone #			
Address					
City		State		Zip	

This authorizes RELEASE of information to	**I authorize the below provider/person to RELEASE information**		
Petaluma/Rohnert Park Health Center	Name		
Fax to: 707-559-7620	Address		
MAIL:	City		
1179 N McDowell Blvd	State Zip		
Petaluma, CA 94954	Phone	Fax	

This information can be used for the following purpose (purposes): ☐ Medical Treatment ☐ Continuity of care ☐ Release to me ☐ Share my health information with others

This authorizes release of the following records

☐ Complete Health Records (1 year from date)

☐ Only Records from Date_____ to Date_____

☐ Other information

The information to be released will be complete health records for 1 year and any indicated information below.

☐ Discharge Summary	☐ Lab Reports	☐ Medications	Pathology Reports
☐ History & Physical	☐ X-Ray Reports	☐ Immunizations	☐ Last PAP
☐ Operative Reports	☐ EKG/ECG Tests	☐ _____	☐ Colon Cancer Screening
☐ ER Records	☐ Progress Notes (last 3)	☐ _____	☐ Last Mammogram

Treatment Records from mental health and/or alcohol/drug dependence and HIV/AIDS information are specially protected and cannot be released to or from Petaluma Health Center unless you sign below.

☐ Release Mental/Behavioral Health Information ☐ Release Treatment for Alcohol and/or Drug Abuse

☐ Release Psychotherapy Notes ☐ Release HIV/AIDS Information

Signature		Date	

a. I understand I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.

c. I understand my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Duration: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here: _____

Petaluma Health Center

42 CFR PART 2

This information is protected by Federal Confidentiality Rules. The Federal Rules prohibit PHC/RP from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Signature		Date	
If signature other than patient printed name and relationship below			
Name		Relationship	