

# RELEASE OF INFORMATION

Patient Name			Date of Birth		
Address			Phone Number		
City		State		ZIP Code	
<b>This authorizes Petaluma/Rohnert Park Health Center to RELEASE:</b>			<b>Petaluma/Rohnert Park Health Center may RELEASE this information to:</b>		
<input type="checkbox"/> Complete Health Records ( 1 year from date)			Relationship		
<input type="checkbox"/> Only Records from Dates _____ to _____			Name		
Other Info:			Address		
			City		
			State		Zip
			Phone		Fax
This information can be used for the following purpose (purposes): <input type="checkbox"/> Medical Treatment <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Release to me <input type="checkbox"/> Share my health information with others					

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

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Lab Reports                | <input type="checkbox"/> Medications   | <input type="checkbox"/> Pathology Reports      |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> X-Ray Reports              | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Last PAP               |
| <input type="checkbox"/> Operative Reports  | <input type="checkbox"/> EKG/ECG Tests              | <input type="checkbox"/> _____         | <input type="checkbox"/> Colon Cancer Screening |
| <input type="checkbox"/> ER Records         | <input type="checkbox"/> Progress Notes<br>(last 3) | <input type="checkbox"/> _____         | <input type="checkbox"/> 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/Rohnert Park Health Center unless you sign below.**

- |   |  |
|---|--|
| <input type="checkbox"/> Release Mental/Behavioral Health Information | <input type="checkbox"/> Release Treatment for Alcohol and/or Drug Abuse |
| <input type="checkbox"/> Release Psychotherapy Notes                  | <input type="checkbox"/> Release HIV/AIDS Information                    |

Signature		Date	
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- 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: \_\_\_\_\_

**42 CFR Part 2:** This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit you 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.

**Re-disclosure:** Once this health information is disclosed, it may no longer be protected under federal privacy law, (HIPAA) California recipients must obtain your authorization before further disclosure.

Signature		Date	
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**If signature other than patient printed name and relationship below:**

Name		Relationship	
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