El Dorado Community Health Centers

Medical Tel: (530) 621-7700
Fax: (530) 621-7713
Dental Tel: (530) 497-5016
Fax: (530) 622-8908

AUTHORIZATION TO RELEASE INFORMATION

PATIENT INFORMATION

Print Patient's Name: _____ Patient's Date of Birth: _____

AUTHORIZED PERSON OR AGENCY

I hereby authorize El Dorado County Community Health Centers to discuss my protected health information with the following:

_____ _____ (_____) _____-_____

Name Relation Phone

INFORMATION TO BE RELEASED

□ All of my medical and dental information

□ My medical and/or dental information only relating to the following treatment(s) or condition(s):

_____

INITIALS REQUIRED IF ANY OF THE FOLLOWING BOXES ARE CHECKED

□ Alcohol / Drug Initials: _____

□ HIV / AIDS Initials: _____

□ Genetic Testing Initials: _____

□ Psychiatry Initials: _____

□ Psychotherapy Initials: _____

ADDITIONAL AUTHORIZATIONS

□ The ability to Make, Change or Scheduled Appointments

□ The ability to Pick up Prescriptions/Medications

THIS AUTHORIZATION SHALL BE IN FORCE AND IN EFFECT FOR ONE YEAR FROM THE DATE BELOW

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

I understand that I have the right to revoke this authorization, in writing, at any time.

Signature: _____ Date: _____

Authority to sign if not patient: _____ Relationship to patient: _____