"Healing with Heart"
Elica Health Centers

1860 Howe Ave, Suite 455
Sacramento, CA 95825
Phone: (916) 454-2345
Fax: (916) 457-2667
www.elicahealth.org

Authorization to Release or Disclose Integrated Health Information

MRN: _____
Office Use Only

Patient Information

Patient Name: _____

Date of Birth: (MM/DD/YYYY) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email Address: _____

Are you registered for the Patient Portal? (*Circle*): YES / NO

Recipient of Health Information

I hereby authorize **Elica Health Centers, its staff and providers, to**:

☐ **Disclose to**
☐ **Request from**

Person/Organization: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Delivery Method: ☐ **Mail** ☐ **Fax** ☐ **Pick Up** ☐ **Secure Email**

Purpose of Disclosure

The purpose of the disclosure of my health information is:

☐ Care Coordination ☐ Legal/Medical Investigation ☐ Billing/Payment Activities ☐ Personal Use

☐ Other (*Specify*): _____

Information to be Disclosed

I authorize the following information to be disclosed:

☐ All of my health information and records, including, my medical records, lab results, radiology results, diagnoses, consult notes, dental records, treatment, and prescriptions.

Date Range: _____

OR

☐ Only the following information (*Specify*): _____

_____

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Information to be Disclosed

I authorize the disclosure of the following **specially protected health information** (**42 C.F.R. 2.34 & 2.35; CA HSC 120980 & 124800**) [*check and initial all that apply*]:

☐ Behavioral Health Treatment (not including psychotherapy notes) Initials: _____

☐ HIV/AIDS Test Results Initials: _____

☐ Genetic Testing Results Initials: _____

☐ Sexually Transmitted or Other Communicable Diseases Initials: _____

☐ Alcohol/Drug Treatment Records Initials: _____

☐ Billing Records Initials: _____

Expiration and Revocation

This Authorization will expire ____ / ____ / _____ (If no date noted, this Authorization is valid one (1) year from the date of my signature below.

I may refuse to sign this authorization, which will not affect my treatment or payment for healthcare.

I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.

Signature

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I understand that my integrated health information is confidential and cannot be disclosed without my written consent unless other authorized or required by law.
- If the receiving part is not subject to medical records privacy laws, the information may be re-disclosed by the recipient, and may no longer be protected by federal or state law. Elica Health Centers shall not be held liable for any consequences resulting from re-disclosure.
- Elica Health Centers will not use or share my health information for marketing or payment without letting me know.
- A copy of this signed form will be provided to me.
- Elica Health Centers may charge an administrative fee to cover the cost of labor, copying, and postage. Health Information office will inform me of any charges and arrange for payment.
- Processing this request may take up to 15 days or as required by law.
- This form complies with requirements of 45 C.F.R. 164.508(c), CA HSC 123111(a), & Civil CA Code §56.11.
- I have had an opportunity to review and understand the content of the authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____

Patient/Representative Signature **Date**

If patient listed above is a minor or unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above your name and complete the following:

_____ _____

Print Name **Relationship to Patient**