"Healing with Heart"
Elica Health Centers

1860 Howe Ave, Suite 455
Sacramento CA 95825
(916) 454-2345 Phone
(916) 634-7286 Fax
www.ElicaHealth.org

Authorization to Release or Disclose Integrated Health Information

MRN:_____
Office Use Only

Patient Information

Patient Name:_____
Date of Birth: (MM/DD/YY)_____
Address:_____
City:_____State:_____Zip Code:_____
Phone Number:_____
Email Address:_____

Are you registered for the Portal? Yes or 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 ☐ Insurance/Benefits ☐ Personal use

☐ Billing /payment activities ☐ 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 & 1249800)**
*(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 on ___/____/____ (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 health care.

I make revoke this authorization at any time before the information I have requested is release 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 are confidential and cannot be disclosed without my written consent unless other authorized or required by law.
- If the receiving party 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 Center shall not be held liable for any consequences resulting from re-disclosure.
- EHC 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.
- EHC 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**