PEOPLE'S COMMUNITY CLINIC

Authorization to Release Protected Health information

PCC staff members are available to help you if you have any questions about this form

By signing this form:

- I release People's Community Clinic, its employees, officers, and physicians from any legal responsibility or liability for disclosure of the information identified for release.
- I understand that once information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not then be protected by federal & state privacy regulations.
- I may revoke this Authorization at any time by providing a written statement to the Health Information Management Dept., except to the extent that PCC or other organization has already completed action on it.

Patient's Name: ____ Other names used: ______________________

Address: ____

City: ____ State: _________________ Zip:_____________________

Date of Birth: ___________________ Soc. Sec. #: _____________________ Phone #:_________________________

Facility to <u>Release</u> Records:

Name: ____

Address: ____

City, State, Zip:_____________________________________

Phone: ____

Fax:____

Facility/Person to <u>Receive</u> Records:

Name: ____

Address: ____

City, State, Zip:_____________________________________

Phone: ____

Fax: ____

Information to be released at the request of the individual:

☐Chart Notes *(Within the last year only)*
☐Laboratory Results *(Within the last year only)*
☐Immunizations Records
☐Radiology / EKG Reports *(All available)*
☐Prenatal Care (Antepartum Care, Delivery, etc.)
☐Verbal Communication (detailed voicemails)
☐Other: ____
Date of Services: ________________________________

Your initials are required for each to release the following information:

___________AIDS/HIV Information
___________Behavioral/Mental Health Information
___________Substance Abuse Information (See Back)
___________Genetic Information
___________STI Information

Purpose for Release:

☐Continued Patient Care ☐Personal Use ☐Attorney / Legal ☐Insurance ☐ Other:________________________

Who should sign this form:

- If the patient is 18 years old or older, the patient must sign.
- If the patient is 18 years old or older but unable to sign, a Legal Guardian (as granted by court order) or Health Care Agent (as granted by a Health Care Power of Attorney) may sign. Please check your relationship:
  ☐Legal Guardian ☐ Health Care Agent
- If the patient is 17 years old or younger, the patient's parent, managing conservator, or legal guardian must sign, unless not required by state or federal law. Please check your relationship:
  ☐Parent ☐Managing Conservator ☐Legal Guardian ☐Other

Signature (required)	**Date (required)**
Printed Name of Person Signing (if not patient)	
This consent will expire one year from the date of signature or _____________________ (date, event, or condition)	

Substance Use Disorder Patient Records Release

PCC staff members are available to help you if you have any questions about this form

Description of Substance Use Disorder Information that may be Disclosed:

1. How much *(for example date range)*: ____

   What kind *(for example diagnosis)*: ____

2. How much *(for example date range)*: ____

   What kind *(for example diagnosis)*: ____

3. How much *(for example date range)*: ____

   What kind *(for example diagnosis)*: ____

Notice to Recipient: This information has been disclosed to you from records protected by federal confidentiality rules (*42 CFR part 2*). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2.

Who should sign this form:

- The patient, even if a minor, must sign.
- EXCEPTIONS:
  - If a court finds that a patient lacks the capacity to handle their own affairs, consent may be given by a Legal Guardian (as granted by a court order) or Health Care Agent (as granted by a Health Care Power of Attorney). If the patient has a medical condition that prevents knowing or effective action on their own behalf, the director (CEO) may consent. Please check your relationship:
    ☐ Legal Guardian ☐ Health Care Agent ☐ Director
  - If the patient is deceased and the disclosure is for any other purpose other than to Vital Statistics, consent may be given by the executor, administrator, or other personal representative appointed under applicable state law. If there is no such appointment, consent may be given by the patient's spouse or, if none, by any responsible member of the patient's family. Please check your relationship:
    ☐Executor ☐Administrator ☐Other Personal Representative ☐Other

Signature (required)	**Date (required)**
Printed Name of Person Signing	
This consent will expire one year from the date of signature or ____________________ (date, event, or condition)	