●13500 Airport Road ●P.O. Box 338 Boonville, CA 95415 ●Telephone: (707) 895-3477 ●Fax: (707) 895-2035

Request for Release of Protected Health Information

To be completed by the patient or the patient's authorized representative:

Patient's Name:____ Date of Birth: ____________________________________

Telephone Number: ___________________________________ Fax Number:_____________________________________

Mailing Address: ______________________________________ City:____

State:____ Zip Code:_______________________________________

Hereby Authorize:

Physician or Provider Name:____

Telephone Number: ___________________________________ Fax Number:_____________________________________

Mailing Address: ______________________________________ City:____

State:____ Zip Code:_______________________________________

To release my confidential health information, as described below, to:

☐ The Anderson Valley Health Center

The following manner:

☐ Copies by mail ☐ Copies by fax ☐ Copies to be picked-up

☐ Other: ____

My authorization is for the use and disclosure of the following records:

☐ Statements of Charges and Payments
☐ *Records of Health Center Visits*
☐ *Mental Health Records*
☐ *Dental Records*
☐ *X-rays and Other Images*
☐ *AIDS (*Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Information
☐ All of the Above
☐ Other:____

My authorization pertains to information generated on the following date(s) or in the following time period:

____

My authorization is given freely with the understanding that:

- I may refuse to sign this authorization.
- I may revoke this authorization at any time, except where information has already been release in reliance on my authorization, provided that my revocation is in writing.
- The Health Center may not condition my treatment on my provision of this authorization.
- This authorization is valid for a ________ day period from the date it is signed or sooner if so specified by me, as indicated below.
- A photocopy or fax of this authorization is as valid as the original.
- The Health Center, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I will be given a copy of this signed authorization if the authorization is at the request of the health center.

This authorization will expire on: ____

______________________________	______________________________
Patient's Signature	Date
Signature of Parent or Guardian	Date

____

Print Name of Parent or Guardian

____

Description of Legal Authority to Act on Behalf of Patient