Anderson Valley Health Center

# Authorization to Release Health Information

*Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.*

Patient's Name: _____ DOB: _____ Telephone: _____

Mailing Address: _____ City/ State/ Zip: _____

| Please **RELEASE** the following information **FROM**: | Please **SEND** the following information **TO:** |
|---|---|
| Name of Provider/Organization/Person: | Name of Provider/Organization/Person: |
| **Anderson Valley Health Center** | |
| Street Address: | Street Address: |
| **PO Box 338** | |
| City/State/Zip: | City/State/Zip: |
| **Boonville, CA 95415** | |
| Telephone Number: | Telephone Number: |
| **(707) 895-3477 ext. 622** | |
| Fax Number | Fax Number |
| **(707) 895-2035** | |

☐ By mail ☐ By Fax ☐ To be picked-up

☐ Email *(**encrypted** & will expire after 7days of opening):* _____

**I authorize the following information to be released:**

☐ Only the following records or types of health information (including any dates):

_____

☐ I specifically authorize release of the following information: Notes:

- Medical Records _____
- Behavioral Health Treatment Information _____
- Lab Test Results _____
- X-Ray Results & Other Images _____
- Financial Information _____

A **separate authorization** is required to authorize the disclosure or use of Psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

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For the Purpose of: ☐ Patient Request ☐ Other: _____

Limitations, if any: _____

Duration: This authorization shall begin immediately and expires on (date): _____

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I have a right to receive a copy of this authorization.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **Anderson Valley Health Center @ 13500 Airport Rd. Boonville, Ca. 95415**
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically or permitted by law.

**Patient or Authorized Representative of the Patient:**

Signed: _____ Print Name: _____

Relationship to Patient:_____ Date: _____

For **Behavioral Health** Records **ONLY**, signature of **MINOR** patient: _____

I authorize: _____ to pick up my medical records.

**PLEASE KNOW IT MAY TAKE UP TO 2 WEEKS FOR RECORDS TO BE SENT.**

**THANK YOU FOR YOUR PATIANCE.**

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***** FOR OFFICE USE ONLY *****

☐ REQUEST COMPLETED:
- DATE: _____
- STAFF INITIALS: _____
- #PAGES: _____

☐ IDENTITY OF INDIVIDUAL AND/OR LEGAL REPRESENTITIVE VERIFIED:

STAFF INITIALS: _____

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**Medical Health, Behavioral Health and Dental Health**
**At Anderson Valley Health Center**
13500 Airport Rd. Boonville, Ca. 95415 or PO Box 338 Boonville, Ca. 95415
Telephone: (707) 895-3477 or Fax: (707) 895-2035