All-Inclusive Community Health Center
1311 N. San Fernando Blvd, Burbank, CA 91504
3920 Eagle Rock Blvd, Los Angeles, CA 90064
Tel: 818-843-9900 Fax: 818-843-9901 E-mail:info@aichc.org

AUTHORIZATION TO DISCLOSE (RELEASE) PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ **Date of Birth:** _____ **Patient #**_____
Last First Middle (MM/DD/YYYY)

Address: _____
Street City State Zip Code

Phone Number: _____ **E-mail Address:** _____ **Date(s) of Service:** _____

Purpose of Release: ❑ Leaving Practice/Change of Doctor (minimum document set) ❑ Personal ❑ Continuity of Care/Treatment
❑ Self/Personal Reasons (minimum document set) ❑ Insurance Reasons ❑ Legal Reasons
❑ Disability (minimum document set) ❑ Other (specify):_____

Physician Practice/Organization Authorized to **Release** Information:

Name: _____

Address: _____

City, State & Zip: _____

Phone #:_____ **Fax #:**_____

Person/Physician/Organization Authorized to **Receive** Information:

Name: _____

Address: _____

City, State & Zip: _____

Phone #:_____ **Fax #:**_____

Information to be released – For the record(s) selected above, specify the content to be released in the area below as Complete Record, Minimum Document Set or Additional Document Set. Each type of record may or may not contain all the documents listed.

❑ Complete Record

❑ Minimum Document Set (the following will be sent)
- ✓ Progress Notes – Last 2 years
- ✓ Radiology (if applicable) – Last 2 years
- ✓ Labs (if applicable) – Last 2 years
- ✓ Other diagnostic tests (if applicable) – Last 2 years
- ✓ Cardiovascular (if applicable) – Last 2 years
- ✓ Consultations – Last 2 years
- ✓ Hospital records – Last 2 years

❑ Additional Documents (Minimum plus selected items)
- ❑ Physician Orders
- ❑ Nurses Notes
- ❑ Graphics
- ❑ Physical Therapy
- ❑ Medication Lists
- ❑ Immunization Records
- ❑ Other/Misc:_____

Permission to release Privileged Information – In compliance with California and Federal statutes which require special permission to release otherwise privileged Information, please release records that pertain to: (Check applicable records to be released)

❑ AIDS/Aids-Related Illness ❑ Developmental Disabilities ❑ Alcohol Evaluation and/or Treatment
❑ HIV Test Results ❑ Psychiatric and all mental health records ❑ Drug Evaluation and/or Treatment
❑ Sexually Transmitted Disease Information ❑ Other:_____

Method of Release : ❑ Mail ❑ Fax ❑ Electronically ❑ Other (please specify) _____

Understanding: Please initial each statement below:

____ I understand that written consent is necessary to revoke this request, and that I can revoke this consent at any time, except to the extent that disclosure has already occurred prior to the receipt of the revocation request. If written revocation is not received, authorization will be considered valid for a period of time not to exceed 90 days from the date of signing. In the case of alcohol or drug records, this authorization well be valid for no longer than reasonably necessary to serve the purpose for this the release is given.

____ I understand that authorization for disclosure is voluntary, and that I can refuse to sign this authorization. The above-named health care provider cannot condition treatment, payment, enrollment or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality riles.

____ I understand that a photocopy of this authorization with my signature is to be considered valid as the original.

_____ _____ _____ _____
Signature of patient or Patient's Legal Representative Name (First Last) Relationship to Patient Date